Northern Inyo Healthcare District

Board Meetings

Compliance, Quality, Safety, and Risk Committee - March 19, 2025

Agenda

Meeting Minutes

Charter

Work Plan

Reports

NOTICE

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS – CQSRC MEETING

March 19, 2025, at 4:00 pm

The CQSRC (Compliance, Quality, Safety, and Risk Committee) will meet in person at 2957 Birch Street Bishop, CA 93514. Members of the public will be allowed to attend in person or via Zoom. Public comments can be made in person or via Zoom:

TO CONNECT VIA ZOOM: (A link is also available on the NIHD Website)
https://us06web.zoom.us/j/85291705552
Meeting ID: 852 9170 5552

PHONE CONNECTION:
888 475 4499 US Toll-free
877 853 5257 US Toll-free
Meeting ID: 852 9170 5552

Board Member, David McCoy Barrett, will attend from 401 Mercer Street, Seattle, WA 98109, via Zoom.

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1. Call to Order at 4:00 pm.
2. Public Comment: At this time, members of the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. The CQSRC is prohibited from generally discussing or taking action on items not included in this Notice.
3. New Business
   a) Meeting Minutes, December 11, 2024 – *Action Item*
   b) Charter – *Action Item*
   c) Work Plan 2025 – *Action Item*
4. Reports - *Information Item*
   a) Compliance Annual Report – *Information Item*
   b) Employee Health and Infection Control Report – *Information Item*
   c) Medical Staff Report– *Information Item*
   d) Cybersecurity Report – *Information Item*
5. Adjournment

In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District Board Governance Committee meeting, please contact the administration at (760) 873-2838 at least 24 hours prior to the meeting.

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Chair Melissa Best-Baker called the meeting to order at 4:05 pm.
PRESENT	Melissa Best-Baker, Chair Jean Turner, Vice Chair David McCoy Barrett, Treasurer Mary Mae Kilpatrick, Member at Large Stephen DelRossi, Chief Executive Officer Alison Murray, Chief Human Resources Officer, Chief Business Development Officer Allison Partridge, Chief Operations Officer / Chief Nursing Officer Andrea Mossman, Chief Financial Officer Adam Hawkins, DO, Chief Medical Officer Sierra Bourne, MD, Chief of Staff Alison Feinberg, Manager of Quality and Survey Readiness, Quality Assurance Dianne Picken, Medical Staff Director Patty Dickson, Compliance Officer Robin Christensen, Manager Employee Health & Infection Control Scott Hooker, Director of Facilities and Property Management
ABSENT	Bryan Harper, ITS Director
PUBLIC COMMENT	Chair Best-Baker reported that at this time, audience members may speak on any items not on the agenda that are within the jurisdiction of the Board. There were no comments from the public.
NEW BUSINESS	
MEETING MINUTES	Motion to approve meeting minutes from September 18, 2024: Turner 2nd: Barrett Passed
CHARTER	The Charter will include: 1. Goals of the committee 2. Responsibilities of the committee 3. Key performance indicators (KPI) that are being tracked Work Plan 1. What the committee will accomplish Calendar 1. When items will be completed Draft charter will be presented March 2025.

REPORTS

COMPLIANCE REPORT

Chair Best-Baker called attention to the Compliance Report.

Dickson noted that the Compliance Report included was the same report from the Board Meeting on November 20, 2024, and asked the Board if they had questions or comments on the report.

Dickson clarified that Language Line is the current interpreter.

EMPLOYEE HEALTH AND INFECTION CONTROL

Chair Best-Baker called attention to the Employee Health and Infection Control Report.

Christensen, Partridge and Hawkins clarified:

1. Blood contamination does not take place during a blood draw.
2. Blood contamination is often discovered when the lab receives and reviews the blood culture when viewing the sample under a microscope.
    a. For example, if skin from the collector gets into the sample.
3. The lab and nurses review each blood contamination case to determine when the contamination took place.
4. Remedial training is provided to staff.

QUALITY REPORT

Chair Best-Baker called attention to the quality report.
Discussion ensued.

MEDICAL STAFF REPORT

Chair Best-Baker called attention to the Medical Staff Report.
Discussion ensued.

FACILITIES REPORT

Chair Best-Baker called attention to the Facilities Report.

Hooker expressed that the list of maintenance projects slated to be completed by the end of 2024 is on target to be completed.

1. The parking lot project is almost complete and we anticipate patients parking in the new parking lot in 2-3 weeks.
2. The flooring project for the Rural Health Clinic is also underway.

CYBERSECURITY

Chair Best-Baker called attention to the Cybersecurity Report.

DelRossi and Dickson pointed out the three third-party cybersecurity issues that occurred this year. Each issue was because another company's cybersecurity failed, NIHD’s cybersecurity was not the cause of the breach.

1. Change healthcare, effect was nationwide
2. Keenan cybersecurity breach, affecting employees and their families.
3. Elevate, affecting 1-2 patients

ADJOURNMENT

Adjournment at 4:30 pm

_____
Jean Turner
Northern Inyo Healthcare District
Chair

Attest: _____
David Lent
Northern Inyo Healthcare District Chair
Secretary

NORTHERN INYO HEALTHCARE DISTRICT
COMMITTEE CHARTER

Title: Compliance, Quality, Safety, and Risk Committee Charter		
Owner: Board Clerk and CFO Assistant	Department: Administration	
Scope:		
Date Last Modified: 03/04/2025	Last Review Date: No Review Date	Version: 1
Final Approval by:	Original Approval Date:	

COMMITTEE PURPOSE

The purpose of the Compliance, Quality, Safety, and Risk Committee (CQSRC) is to guide and assist the Governing Board and Executive Staff in their responsibility to oversee compliance, quality, safety, and risk in order to meet or exceed regulations and standards that govern health care organizations.

COMMITTEE RESPONSIBILITIES

The committee is responsible for reviewing, monitoring, and ensuring that the organization maintains high standards in CQSR critical areas to ensure patient safety, compliance with applicable regulations, and the overall well-being of the community served.

COMMITTEE GOALS

1. Directly oversee that quality assurance and improvement processes are in place and operating effectively in the District.
2. Review reports and data to provide strategic oversight for quality of care and treatment, and recommend new services or programs to the Board of Directors.
3. Review reports and data to provide strategic oversight for compliance, risk, and safety to ensure conformity with regulations and standards that govern health care organizations, and to make recommendations to the Board of Directors.
4. Create and review CQSRC Annual Work plan.
5. Educate the Board within the areas authorized by this committee.

COMMITTEE MEMBERSHIP

1. The CQSRC shall include the Board of Directors, Executive Team, and the following subject matter experts:
    a. Information Security Officer
    b. Compliance Officer
    c. Director of Facilities
    d. Director of Medical Staff
    e. Manager of Infection Prevention and Employee Health
    f. Manager of Quality and Survey Readiness
2. The members of the Board of Directors are the only members with voting privileges
3. On an ad hoc basis, the Board may allow a member of the community to participate in the proceedings. The community member will not have voting rights and will exist solely to gauge feedback or recommendations to the Board.

FREQUENCY OF MEETINGS

1. The CQSRC shall meet quarterly.
2. Additional meetings may be scheduled on an as-needed basis.

PUBLIC PARTICIPATION

1. All CQSRC meetings shall be announced and conducted according to the Brown Act. The general public, patients, their families and friends, Medical Staff, and District staff are always welcome to attend and provide input.

FREQUENCY REVIEW/REVISION

1. The CQSRC shall review the Charter biennially and as needed.
2. Revisions will be reviewed at CQSRC and a recommendation will be presented to the full Northern Inyo Healthcare District Board of Directors for approval.

RETENTION AND DESTRUCTION OF RECORDS

Information packets and minutes for these committee meetings are part of the permanent records of the District.

REFERENCES

1. The Joint Commission 2025. Critical Access Hospital. MS.07.01.01.
2. The Joint Commission (2024), IC.04.01.01.
3. The Joint Commission (2024) IC .06.01.01
4. The Joint Commission. (2024). MM.09.01.01
5. Centers for Medicare & Medicaid Services. (2022). Infection Prevention and Control and Antibiotic Stewardship Program Interpretive Guidance Update. Retrieved from https://www.cms.gov/files/document/qso-22-20-hospitals.pdf
6. California Department of Public Health (CDPH). (2024). Healthcare-Associated Infections HAI Program: Antimicrobial Resistance (AR). Retrieved from https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/AntimicrobialResistanceLandingPage.aspx
7. California Department of Public Health (CDPH). (2020). Healthcare-Associated Infections HAI Program. HAI Reporting Guidance for California Hospitals. Retrieved from https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/CA_SpecificReportingGuidelines.aspx
8. General Compliance Program Guidance 2023. Retrieved from https://oig.hhs.gov/compliance/general-compliance-program-guidance/
9. The Joint Commission 2025. Critical Access Hospital. IM.02.01.03.
10. The Joint Commission 2025. Critical Access Hospital. LD.01.03.01
11. The Joint Commission 2025. Critical Access Hospital. LD.07.01.01.
12. The Joint Commission 2025. Critical Access Hospital. LD.03.01.01.
13. The Joint Commission 2025. Critical Access Hospital. LD.04.01.01.
14. The Joint Commission 2025. Critical Access Hospital. EC.01.01.01.

Supersedes: Not Set

	Goal/Information	Notes	Timeline
1.	Committee 2025 Work plan Review		Annual review
2.	Track and trend individually identifiable medical information breaches and reduce associated risk.	Compliance	Annually
3.	Review audits to prevent and detect fraud, waste, and abuse, ensure compliance and reduce risk for the District.	Compliance	As needed
3.	Review HIPAA (Health Information Portability and Accountability Act) Risk Assessment and Security Risk Assessment to ensure a maximal risk reduction strategy.	Compliance/ITS	Annually
	Cyber Security Penetration Testing tracking and trending to monitor risk reduction.	ITS	Annually and as needed
5.	Review Workplace Violence Trends to ensure strategic guidance to increase safety and reduce risk.	Safety/Facilities	Annually
6.	Review the Medical Staff credentialing and privileging processes and understand their impacts to patient safety and the delivery of care	Medical Staff Office	Annually
7.	Review Hospital-Acquired Infections Data Related to Surgical Site Infections, Device-Associated Infections, and Multi-Drug Resistant Reporting to NHSN	Infection Prevention	Quarterly
8.	Track and trend Antibiotic Stewardship Activities and its impact on District patients.	Infection Prevention	Quarterly
9.	Review Employee Sharps Injury Data	Infection Prevention	Annually
10.	Review Healthcare-Worker Influenza Vaccination Rates	Employee Health	Annually
11.	Review Employee Safe Patient Handling Injuries	Employee Health	Annually
12.	Quality Incentive Pool (QIP) Program	Quality	Annually
13.	Quality reporting education	Quality	Annually
14.	Review the Environment of Care to ensure conformance with regulatory agencies.	Safety/Facilities	Annually

NORTHERN INYO HEALTHCARE DISTRICT
REPORT TO THE BOARD OF DIRECTORS
FOR ACTION

Date: February 6, 2025

Title: 2024 Annual Compliance Report

Synopsis: The Compliance Department Annual Report provides information needed for the Board of Directors to provide the oversight required by the Health and Human Services Office of Inspector General (OIG). It provides insight into the work occurring in all areas of the seven essential elements of a Compliance Program as outlined by the HHS OIG. All information in the report has been summarized; however, additional details will be provided to the Board of Directors upon request.

I recommend that the Board of Directors accept this report.

Prepared by: Patty Dickson, Compliance Officer

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Approval: _____ Submitted by: _____
Chief Officer

NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.

Northern Inyo Healthcare District

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Bishop, CA 93514
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Annual Compliance Report –CY 2024
February 5, 2025

Comprehensive Compliance Program Definitions:

1. **Audits** - A wide variety of audits in the Compliance Program review for privacy concerns, language access issues, and fraud, waste, and abuse. Auditing and monitoring is one of the seven essential elements of an effective compliance program.
2. **Security Risk Assessment**—The District HIPAA (Health Insurance Portability and Accountability Act) Security Risk Assessment is completed annually and as needed by Compliance and Information Technology (IT) Security.
3. **SAFER** - Office of National Coordinator of Health Information Technology SAFER ((Safety Assurance Factors for EHR (Electronic Health Record) Resilience)) is completed annually by IT, Informatics, and Compliance.
4. **Compliance Workplan** - The Compliance Workplan is updated annually and as needed to adjust the focus of certain audits in alignment with the Office of Inspector General of the Department of Health and Human Services, our local Medicare Administrative Contractor (MAC) Noridian, and other regulatory agency priorities.
5. **Conflicts of Interest** – This component of the Compliance Program ensures that no parties use or conduct District business for personal financial gain.
6. **Privacy Investigations –** Privacy investigations can arise due to complaints, access audits, HIMS audits, and anonymous reporting.
7. **Investigations—**Other compliance-related investigations are conducted to avoid regulatory non-compliance and respond to regulatory agency inquiries and investigations. Enforcement and discipline are among the seven essential elements of an effective compliance program, as is reporting as required to regulatory agencies and the Board.
8. **Compliance Committees—**This section provides a brief overview of the work of the Compliance committees and subcommittees.
9. **Issues and Prevention** – The Compliance Team researches numerous questions, concerns, and regulatory issues to allow other NIHD team members to take a proactive approach. Education and training, along with response and prevention, are two of the seven essential elements of an effective compliance program.
10. **California Public Records Act (CPRA) Requests**—The Compliance Officer is responsible for receiving and reviewing public records requests and researching, investigating, redacting, and fulfilling them.
11. **Policies and Procedures—**Policies and procedures are vital to the organization as they outline expectations and processes for the workforce. Having written policies and procedures is one of the seven essential elements of an effective Compliance Program.

12. **Unusual Occurrence Reports**—The Compliance Team processes and tracks all unusual occurrence reports for the District. Compliance provides quality data to leadership and teams for monitoring and trending. Compliance also manages the software, reporting, user configuration, and resolution of all UORs.
13. **Regulatory Updates—**Compliance requires knowledge of updates and changes to state and federal regulations. The Compliance Department has implemented regulatory monitoring software to ensure we are aware of and plan for upcoming effective dates for new and changing regulations.

The Compliance Department consists of a team of two full-time employees, Conor Vaughan, Compliance Analyst, and Patty Dickson, Compliance Officer.

The Compliance Reports help the Board of Directors and Executives fulfill their governance and oversight roles. Governing board and executive oversight of compliance is one of the seven essential elements of an effective compliance program.

Report

1. Audits

A. Electronic Health Record Access Audits—The Compliance Department Analyst, Conor Vaughan, completes audits for patient information systems access to ensure employees, providers, contractors, and vendors access protected health information on a work-related, need-to-know, and minimum-necessary basis.

i. Cerner semi-automated audit software tracks all workforce interactions and provides a summary dashboard for the Compliance Team. The dashboard provides "flags" for unusual activity, which require further investigation and review by the Compliance Team. The majority of access audits are a manual process involving reviewing hundreds of thousands of lines of data in Excel spreadsheets.

ii. With assistance from ITS and Project Management, the Compliance Department is currently performing the due diligence necessary to implement a fully automated auditing solution, Protenus. Once implemented, this software will save the Compliance Department over 1300 hours per year, allowing the Compliance Team to use those hours to improve other areas of District regulatory compliance. See sample report from Protenus, attachment 1.

ii. The following is the CY24 activity:

a. New Employee Audits (30 days): 35
   I. Flags: 1
   II. Flags resulting in policy violations: 1
   III. The 30-day audit for new employees was added to the access audit plan in 2024 as a part of a Protected Health Information (PHI) breach corrective action plan.

b. New Employee Audits (90 days): 126
   I. Flags: 1
   II. Flags resulting in policy violations: 0

c. For-Cause Audits: 39
   I. Flags: 8
   II. Flags resulting in policy violations: 0
   III. Flags resulting in disciplinary action: 6

d. In "own" chart flags: 43
    I. Flags resulting in policy violations: 17
        i. Provided education and training: 17
        ii. Repeat violations: 0
e. Same Last Name Search Flags: 890
    I. Resulted in follow-up with the employee: 10
    II. Flags resulting in policy violations: 0
f. Third-Party Vendors (ex. Our billing or coding company): 66
    I. Flags: 1
    II. Flags resulting in policy violations: 0
g. High Profile Persons: 26
    I. Flags: 0
    II. Flags resulting in policy violations: 0
h. Random Employee Audits: 28
    I. Flags: 0
    II. Flags resulting in policy violations: 0

B. Business Associates Agreements (BAA) audit
    i. Business Associates are vendors who access, transmit, receive, disclose, use, or store protected health information to provide business services to the District. These vendors range from our billing and coding companies to companies that provide medical equipment that transmits protected health information to the electronic health record. The Business Associates Agreements assure NIHD that the vendor is accountable to the strict governmental regulations regarding using, transmitting, and storing protected information to protect NIHD and NIHD patient information.
    ii. In 2025, compliance will vet high-risk business associates to ensure compliance with BAAs and privacy and security laws.
    iii. NIHD has nearly 100 BAAs.
C. Compliance Department Contract and Agreement reviews/audit
    i. Documents processed for CY 24
        a. Approximately 250 agreements, amendments, or termination notices were reviewed and completed.
        b. ~10 are currently in progress
D. HIMs (Health Information Management) scanning audit
    i. To be conducted by HIMS, and summary reports will be sent to Compliance
    ii. No reports have been received to date
E. Email security audit/reviews
    i. Reviewed at least once a month
    ii. Review email security systems for violations of data loss prevention rules
        a. Typically, it results in reminder emails to use email encryption sent to workforce members.
        b. Occasionally, this results in full investigations of potential privacy violations.
F. Language Access Services Audits and Reviews
    i. Interpretive (spoken word) services are provided via telephone and video interpreting units from third parties, CyraCom and Language Line.
        a. NIHD has provided 88,429 minutes of interpreting services to our patients at a cost to the District of $97,667.62. See attachment 2.

ii. Translation services (written word) services are provided via Language Line Translation Services. NIHD spent $6,707.64 on translation services in 2024.
iii. NIHD provided services in the following languages in 2024:
    a. Spanish (21 countries claim Spanish as an official language)
    b. American Sign Language
    c. Mandarin (China, Taiwan, and Singapore)
    d. Gujarati (India/Pakistan)
    e. Thai (Thailand)
    f. Arabic (25 countries claim Arabic as an official language)
    g. Armenian (Armenia)
    h. Vietnamese (Vietnam)
    i. Quechua (Andean regions of South America)
    j. French
iv. Laws require providing language access services to all patients with limited English proficiency at no cost to the patient.
v. Language Access regulations are enforced by the HHS (US Department of Health and Human Services) Office of Civil Rights.
vi. Compliance has vetted and selected Pocketalk's HIPAA-compliant handheld AI interpreting device. We will update Language Access Services Policies and Procedures and roll the product out throughout the District. See attachment 3.

G. 340B program audits
    i. The 340B drug program is designed to provide rural and underserved communities with access to discount drug prices, allowing the facility to save several hundred thousand dollars annually. The district uses those funds to improve services provided to the community.
    ii. Annual 340B audit has been scheduled for 2025 with SpendMend (formerly TurnKey)
        a. The Compliance Department recognizes Becky Wanamaker and Jeff Kneip for their excellent work maintaining the compliance of our 340B program.

H. Narcotic Administration/Reconciliation Audit
    i. Compliance works with Pharmacy to review narcotic administration and compliance with professional standards and regulations.

I. Vendor Diversity Audit – NIHD has approximately 1200 vendors.
    i. NIHD currently has one certified diverse vendor.
    ii. Health and Safety Code Section 1339.85-1339.87 required the Department of Health Care Access and Information to develop and administer a program to collect hospital supplier diversity reports, including certified diverse vendors in the following categories: minority-owned, women-owned, lesbian/gay/bisexual/transgender-owned, and disabled veteran-owned businesses.
    iii. There are currently no regulatory requirements for utilizing diverse vendors or outreach to diverse vendors. There are changes to this state regulation in 2025. Compliance is reviewing the changes and updating our policies as needed.

J. Provider Verification Audits
    i. Compliance verified over 400 providers for state and federal exclusions in CY 2024.
    ii. No exclusions were found for verified providers.
    iii. NIHD may not bill for referrals for designated health services from excluded providers. Billing for referrals from excluded providers could put NIHD at risk for false claims.

K. Coding Audits and Charge Master Audits

i. UASI has provided coding quality reports.
    a. UASI has provided education to providers.
ii. Charge Master Audit
    a. The audit conducted by CliftonLarsonAllen identified opportunities in multiple areas of the chargemaster. These are the focus of multiple revenue cycle committees.

L. In 2024, NIHD employees have read 98.2% of assigned Compliance and Privacy policies.

2. **HIPAA Security Risk Assessment (SRA)** – Completed in December 2024.
   A. This is a mandatory risk assessment under the jurisdiction of the HHS OIG. See attachment 4 for an overview of the 2024 results.
   B. The Compliance Officer (Patty Dickson) and Security Officer (Bryan Harper) work on this risk assessment together. We are moving the process of a once-per-year review to a software-driven continuous process. See ComplyAssistant information in attachment 5.
3. **Office of National Coordinator of Health Information Technology SAFER Audit** ((Safety Assurance Factors for EHR (Electronic Health Record) Resilience))
   A. Nine of nine sections of the SAFER audit were completed by June 1, 2024.
   B. Completion of all nine sections is required for MIPS (Merit-based Incentive Payment System) data submission.
   C. MIPS data is the quality-of-care data submitted by the Quality Team. MIPS documents improvements in patient care measures and outcomes and is worth millions of dollars for NIHD.
4. **Compliance Work Plan** – Updated for Calendar Year (CY) 2025. See attachment 6.
5. **Conflicts of Interest**
   A. All new employees complete and return COI questionnaire forms.
   B. We sent all current employees the new format COI questionnaire form in July 2024.
      i. We have received over 350 completed forms.
      ii. We have reduced the time the Compliance Department spends on this process by approximately 85%, which saves the District over $25,000.
   C. No COI forms submitted to the Compliance Department noted any knowledge or concern for the following:
      i. Business transactions with an aim for personal gain.
      ii. Gifts, loans, tips, or discounts to create real or perceived obligations.
      iii. Use of NIHD resources for purposes other than NIHD business, NIHD-sponsored business activities, or activities allowed by policy.
      iv. Bribes, kickbacks, or rewards with the intent to interfere with NIHD business or workforce.
      v. Use of NIHD money, goods, or services to influence government employees, for special consideration, or for political contribution.
      vi. False or misleading accounting practices or improper documentation of assets, liabilities, or financial transactions.
6. **Privacy Investigations**- See attachment 7.
   A. Privacy investigations/potential breaches for 2024:
      i. Reported to Compliance – 29
      ii. Reported to CDPH/OCR – 7
      iii. Investigations (2024) still active in the Compliance Department - 0
      iv. Investigations closed by the Compliance Department with no reporting required - 22
   B. Outstanding breach cases reported to CDPH
      i. CDPH has notified NIHD that the Medical Breach Enforcement Section (MBES) will begin investigating its backlog of breaches. MBES can review and investigate breaches for

seven years. The MBES team was reassigned to contact tracing during the pandemic and is now working to resolve the oldest reported potential breaches first.

a. Privacy investigations from 2023
    I. Reported – 10
        i. 4 are closed
b. Privacy investigations from 2022
    I. Reported – 6
        i. 3 are closed
        ii. NIHD received notice that CDPH assigned a $45,000 administrative penalty for a breach in 2022.
            1. This was an intentional breach by the former employee.
            2. Compliance was able to negotiate a $30,000 Settlement Stipulation. NIHD has paid this administrative penalty.
c. Privacy investigations from 2021
    I. Reported – 4
        i. 3 are closed
d. Privacy investigations from 2020
    I. Reported – 17
        i. 11 are closed
        ii. 3 may be assigned an administrative penalty or fine
e. Privacy investigations from 2019
    I. Reported - 11
        i. 7 are closed
f. Privacy investigations from 2018
    I. Reported - 23
        i. 22 are closed
g. Privacy investigations from 2017
    I. Reported -22
        i. 17 are closed
h. Privacy investigations from 2016
        i. CDPH is still investigating 1

ii. CDPH Status definitions
    a. Closed – CDPH investigation was completed, and a determination was made.
    b. In Progress – CDPH has assigned an intake ID and may have completed some portion of the investigation.
    c. Submitted – CDPH has not assigned an intake ID or reviewed the case.

iii. CDPH Determination definitions
    a. Unsubstantiated – CDPH was unable to prove a violation of the privacy laws occurred (or the privacy law was updated in the interim between submission and their processing of the report)
    b. Substantiated without deficiencies—CDPH found that a violation of the privacy laws occurred, but NIHD had the correct policies/procedures, training/education, and corrective actions to ensure any harm has been mitigated and reduced the risk for recurrence.
    c. Substantiated with deficiencies—CDPH has found that a violation of the privacy laws occurred and determined that further action by NIHD is needed to reduce the risk of recurrence. CDPH requires a corrective action plan to be submitted within a

few days of receipt of the determination letter. Once the corrective action plan has been accepted, CDPH sends the case to CDPH Administration to determine if fines and administrative penalties will be assessed.

7. **Investigations**
   A. Compliance conducted or assisted with approximately 45 investigations during 2024, including, but not limited to, the following:
      i. California Department of Labor, Department of Industrial Relations
         a. Response to investigation regarding California Labor Code, Division 2, Part 7 relating to a contractor participating in the Pharmacy/Infusion Construction Project.
      ii. Health and Human Services Office of Civil Rights (OCR)
         a. Business Associate Data Breach – Keenan
            I. OCR reviewed the 700-page response submitted by NIHD for this breach by a business associate.
            II. OCR provided recommendations for improvement.
            III. The case was closed without further action on December 30, 2024. See attachment 8
            IV. The recommendations will be completed with the implementation and completion of tasks in the ComplyAssistant software.
      iii. California Department of Public Health, Licensing and Certification
      iv. Internal investigations
   B. Regulatory Submissions
      i. Health Care Access and Information (HCAI – formerly OSHPD)
         a. Vendor Diversity—On June 3, 2024, Compliance reported the required vendor diversity information due by July 1, 2024. NIHD had three certified diverse vendors. NIHD spent ~$66k with certified diverse vendors, approximately 0.08% of its total procurement. These reports are due before July 1 annually.
         b. Hospital Fair Billing Practices – On June 11, 2024, Compliance reported NIHD's Financial Assistance and Charity Care Programs, along with postings in all registration areas of the District, to HCAI. Additionally, all information was submitted explaining how NIHD complies with all language access regulations, as required. We are required to update this information any time the policies are updated, which most recently occurred in December 2024.
         c. CMS Hospital Price Transparency—On August 7, 2024, NIHD received a Notice of Non-Compliance from CMS. NIHD's Price Transparency webpage did not meet regulatory requirements. NIHD had 90 days to have a fully functional and compliant price estimator and machine-readable chargemaster file.
            I. Project Manager Lynda Vance led an NIHD team assembled to assess, create, and execute a corrective action plan.
            II. On November 8, 2024, NIHD received notification that the reviewed section complies with Hospital Price Transparency regulations. See attachment 9.
            III. Thanks to Lynda's continuous follow-up and pressure on internal and external teams, NIHD avoided tens of thousands of dollars in fines.
            IV. NIHD Business Office still performs weekly follow-up calls with Cerner and other vendors to ensure the process works well and complies with the regulations.
   C. Subpoenas

i. The Compliance Department also accepts and completes subpoena service for cases related to District business. This includes subpoenas for NIHD business records and appearances. Subpoenas for Medical Records are processed by the Health Information Department (HIM).
ii. The Compliance Team has facilitated 59 subpoenas for records or appearances in CY 2024.

8. Compliance Committees

A. Compliance and Business Ethics Committee (CBEC**)**
   i. No meetings since March 17, 2023
B. Billing and Coding Compliance Committee (BCCC) reports to the CBEC committee.
   i. This group reviews billing and coding issues, chargemaster changes, and policies that affect billing, coding, and accounting. The Manager of the Business Office chairs this committee.
C. Business Compliance Team (BCT) reports to the CBEC Committee.
   i. This group reviews all Conflict of Interest questionnaires that list potential conflicts to determine the appropriate and consistent method of addressing the conflict. The Compliance Officer chairs this subcommittee, which meets ad hoc or via serial meetings using Smartsheet.
D. Forms Committee
   i. NIHD develops forms in compliance with our Forms Control Policy. Forms are branded with NIHD logos. Standardized templates, designated fonts, official translations, mandatory non-discrimination and language access information create compliant and consistent documentation for the District.
   ii. We have added Barbara Laughon to this committee to ensure her review and approval of all signage and postings other than those posters legally required by employment law.
   iii. One meeting has been held in 2024. District reorganization has slowed the form development and approval process.
   iv. The Forms Committee is transitioning to serial meetings via Smartsheet to facilitate faster form approvals.

9. Issues and Prevention

A. Compliance researched over 100 issues for the District in 2024. They include adolescent privacy regulations, billing issues, consent, and regulatory reporting. The Compliance Team proactively approaches all matters brought to our attention.

10. CPRA (California Public Records Act) Requests

A. Compliance has received thirteen (13) CPRA requests in CY 2024.
   i. All thirteen were completed timely, per regulatory standards.

11. Policy and Procedures

A. Clear and current policies are the basis of an effective and efficient organization.
B. The Board must review and approve policies every two years, and the Executive Team or the Medical Executive Committee must review and approve procedures every two years.
C. Written policies and procedures are one of the seven essential elements of an effective Compliance Program, per the Health and Human Services Office of Inspector General. The compliance officer manages user set-up, policy administration, and other software optimization.
A. Policy and Procedure Audits:
   i. NIHD has approximately 1155 policies and procedures.
   ii. NIHD leadership teams consistently work on regulatory compliance through policy updates and reviews.

B. Leaders can also use reporting from the system to ensure NIHD team members are current with reviewing policies.
C. A software administrative group that tracks policy life cycles and the approval process consists of Ashley Reed, Sarah Rice, Dianne Picken, Cori Stearns, Patty Dickson, and Veronica Gonzalez.

12. Unusual Occurrence Reports (UOR)

A. UOR data for Calendar Year 2024. See attachment 10
   i. Notable trends out of 515 UORs received in CY 2024:
      a. Complaints and requests to review billing and care are the most frequent UORs. These two areas represent 138 of the 515 UORs (27%).
         I. We are addressing some trending issues:
            i. Billing complaints
            ii. Communication and customer service concerns
      b. NIHD had nine reports of workplace violence.
      c. Medication occurrences and errors are the third highest volume in UORs. However, NIHD's medication error rates are well below national averages for error rates. Medication Errors are administration errors that reach the patient. See attachment 11.
      d. Attachment 11 includes a list of systemic changes implemented based on action plans developed during the UOR review and investigation process.
         I. Five systemic changes were the result of patient complaints.
         II. Three systemic changes resulted from safety and security occurrence reports.

B. The current review process for UORs.
   i. The Compliance Team currently receives all UORs in Complytrack.
      a. Many patient complaints and concerns calls are transferred to the Compliance Team for intake and assistance.
      b. The Compliance Team provides response letters for patient complaints. Per District policy and regulatory guidance from CMS, the average response time for complaint letters should be no more than 7 days.
   ii. UORs are triaged and assigned to appropriate department leaders for review. Leaders are contacted via email and phone for urgent UORs.
   iii. The Compliance team reviews replies, ensures thorough responses and corrective actions, provides follow-up letters to patients, and ensures the executive team is aware of all areas of concern.
   iv. The Compliance Officer follows up with leaders who are having difficulty responding promptly and attempts to assist them with a resolution.
   v. The Compliance Team ensures that UORs are closed after a thorough review, corrective actions, and, in most cases, resolution.

13. Regulatory Updates

A. An introduction to another Compliance Department Project is included in attachment 12.
B. The Board will receive regulatory changes with recent or near-future effective dates in each Compliance Report.
C. Currently, the software has only been rolled out to the Revenue Cycle Director, Compliance Department, and the Director of Inpatient Nursing. We will roll out to additional leaders in the future.

D. To ensure no significant changes were missed during 2024, the Compliance Officer reviewed approximately 350 regulatory updates with effective dates in 2024. Relevant regulations were accepted and assigned to verify compliance.

Attachment 1

PROTENUS

Report Generated **November 26, 2024**

Not real information

Case Information

Case 545

Rylee Q Grant accessed Ashley Barrows on 6/27/2020

EMR User	Patient	Case Created
Rylee Q Grant	Ashley Barrows	July 2, 2024 9:04 AM PDT by Nicholas Culbertson
Case Owner	**Resolution**	**Case Type**
Tom Chelchowski	VIOLATION	VIP

Caseflow

Case Created

Nicholas Culbertson Jul 2, 2024 9:04 AM PDT

Privacy Assessment Added Activity from 06/26/2020 through 06/27/2020

Added by Protenus Jul 2, 2024 9:04 AM PDT based on data available

Assessments

A Nurse in the NICU questionably accessed a VIP's medical record

This user accessed 14 patients on this day.

This user accessed 13 NICU patients and 1 pediatric patient.

This user searched for this patient by name (search query: "Ashley Barrows").

This user searched for 1 (out of 14) patients by name on this day.

This user spent 14 minutes and 26 seconds in this patient's medical record.

This user did not chart or document in this patient's medical record.

This user has never accessed this patient before.

This user's others patients share departments that this patient does not share: NICU (100%).

This user has violated privacy in the past.

This patient was recently mentioned in the news (https://www.10tv.com/article/child-prodigy-needs-a-heart-transplant).

Suspicion Score: 93

Assessments and suspicion score generated based on data available: 11/12/2023

Case escalated to Nursing Leadership, 11/25/2024

Not real information

eiopiroeuq

Note Added

Workforce member Rylee Q Grant accessed Ashley Barrows as a result of searching this patient by name. This access is suspicious because the workforce member is not part of the patients care team and the patient has no upcoming appointments with this workforce member.

Case escalated to HR, 11/25/2024

Case Resolved as Violation - Privacy

User & Patient Details

EMR Record Epic Teresamouth

Rylee Q Grant

Desiree E Cook 5/3/24 – 9/10/24

Details

NP
via Lawson

RGrant1

10/8/1988 : 36 years old

5/4/2024

08989 Buckley Islands Suite 376
Breannaburgh, Tennessee 79801
via ADP

Medical Record Epic New Denise

Ashley Barrows

VIP

Details

1/25/2024 4:34 PM PST

Office Visit, Heart Center

9/26/2016 : 8 years old

Female

SB911448397652415
IK291274884947147
VR286498952356833

869 Jefferson Mills
Lake Daniel, Arkansas 22014
via Salesforce

None

NICU
via Epic

Specialties	Intensive Care
Service Area Type	Nursing Home
Service Area	Richie Center for Rehabilitation
Facility	SHIRE UNIT/DONOR FACILITY

NICU
via Lawson

Associated Roles

NP
via Lawson

Start Date	None Provided
End Date	None Provided
Work Email	RGrant1@northside.org
Organization	NICU
Title	Nurse Practitioner

Admin
via Workday

Start Date	None Provided
End Date	None Provided
Work Email	rylee.grant@gmail.com
Organization	Community Hospital
Title	Volunteer

Contacts

Emily J Morgan
via Meditech

Relationship	Manager
Home Phone	(565)852-4156x64447

70139815

Student

Unknown

4430 Blue Spruce Lane
Baltimore, MD 21212
via Epic

443-416-9693
via Epic

Contacts

Will Barrows
via Epic

Relationship	Father
Home Phone	1-426-659-9298

Encounters

Future Encounters

No Future Encounters

Past Encounters

Office Visit, Heart Center
via Epic

Date/Time	1/25/2024 4:34 PM PST – 6:34 PM PST
Viewed By	Sara B Golden
Providers	Valerie D Coffey
Financial Num.	20098442586039

Office Visit, Heart Center
via Epic

Date/Time	6/15/2020 10:00 AM PDT – 12:15 PM PDT
Providers	Nancy D Davis
Financial Num.	96989874490804

Vacation Address 8663 Moore Shores Apt. 171
West Gina, Minnesota 03563

Not real information

Language Acess Services

Attachment 2

Interpreting	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Total
Language Line - Phone minutes provided	1,221	1,453	1,626	1,705	1,630	999	345	273	330	436	141	277	
Language Line - Phone - cost	$1,159.95	$1,380.35	$1,544.70	$1,619.75	$1,548.50	$949.05	$327.75	$259.35	$313.50	$414.20	$133.95	$263.15	
Language Line - Video - minutes provided	3,689	2,952	4,247	4,948	5,861	2,547	2,097	2,288	2,224	3,277	2,625	3,189	
Language Line - Video - Cost	$5,533.50	$4,426.00	$6,366.65	$7,422.00	$8,800.50	$3,820.50	$3,145.50	$3,432.00	$3,656.04	$4,915.20	$3,937.50	$4,783.50	
Cyracom - Phone - minutes provided	1,415	1,201	1,754	959	719	2,294	3,186	4,577	3,329	4,014	2,908	3,019	
Cyracom - Phone - Cost	$1,035.03	$855.15	$1,315.50	$616.65	$469.14	$1,720.50	$2,297.73	$3,183.48	$2,391.30	$2,841.21	$2,051.04	$2,161.85	
Cyracom - Video - minutes provided	154	142	232	77	243	1,692	1,689	1,844	775	823	689	314	
Cyracom - Video - Cost	$115.50	$106.50	$174.00	$57.75	$182.25	$1,269.00	$1,267.75	$1,389.50	$581.25	$617.25	$516.75	$298.45	
Total Minutes of interpretive services provided	**6479**	**5748**	**7859**	**7689**	**8453**	**7532**	**7317**	**8982**	**6658**	**8550**	**6363**	**6799**	**88429**
Total Cost of interpretive services provided	**$7,843.98**	**$6,768.00**	**$9,400.85**	**$9,716.15**	**$11,000.39**	**$7,759.05**	**$7,038.73**	**$8,264.33**	**$6,942.09**	**$8,787.86**	**$6,639.24**	**$7,506.95**	**$97,667.62**
Translation													
Language Line Translation Services - Cost	$1,000.85	$0.00	$107.55	$268.31	$1,265.07	$2,861.00	$99.00	$0.00	$1,105.86				**$6,707.64**

In California healthcare facilities, the use of handheld AI interpreting devices is generally allowed, but with some important legal and ethical considerations.

Key Legal Considerations:

1. **Compliance with Language Access Laws** – California law (e.g., the Dymally-Alatorre Bilingual Services Act) and federal regulations (e.g., Title VI of the Civil Rights Act and Section 1557 of the Affordable Care Act) require healthcare providers to offer qualified interpreters for Limited English Proficiency (LEP) patients. AI devices may not always meet the requirement of a *qualified interpreter* unless they are proven to be highly accurate.
2. **HIPAA & Patient Privacy** – Any AI interpreting device used must comply with HIPAA (Health Insurance Portability and Accountability Act) regulations to protect patient information. If the device transmits data over the internet or stores information, it must have strong security measures.
3. **Accuracy & Medical Risk** – AI translation tools can sometimes misinterpret medical terminology, leading to errors in patient care. Pocketalk displays the spoken words on the screen to verify the "AI" heard what the speaker said correctly.
4. **Acceptability by Healthcare Facilities** - Hospitals or clinics should develop internal policies for the use of AI interpreting devices.

POCKETALK

Pocketalk offers instant, accessible translation, giving every patient a chance to be heard and understood and improving the healthcare experience for all.

- HIPAA and GDPR compliant.
- Reduce reliance on language lines without slowing down your staff.
- Provide security and confidentiality for the most sensitive conversations.
- Easily export translations to patient files, spending less time charting and documenting.

Image and camera translation

The Pocketalk camera takes a photo and the large touchscreen displays translated text directly on top of the image. Pocketalk can provide an optional audio translation for the camera-translated text as well.

NIHD anticipates a savings of $50-70K in year one, and a $60-8k savings in years two and three following implementation.

We expect improved patient and workforce satisfaction and a decrease in delays in care compared with access times for phone and video interpreting.

Phone and video interpreting will still be available for certain critical conversations and American Sign Language patients.

Security Risk Analysis Tool

Application Version: 3.5

Risk Report

12-20-2024

DISCLAIMER
The Security Risk Assessment Tool at http://HealthIT.gov is provided for informational purposes only. Use of this tool is neither required by nor guarantees compliance with federal, state or local laws. Please note that the information presented may not be applicable or appropriate for all health care providers and professionals. The Security Risk Assessment Tool is not intended to be an exhaustive or definitive source on safeguarding health information from privacy and security risks. For more information about the HIPAA Privacy and Security Rules, please visit the HHS Office for Civil Rights (OCR) Health Information Privacy website at: http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

NOTE: The NIST Standards provided in this tool are for informational purposes only as they may reflect current best practices in information technology and are not required for compliance with the HIPAA Security Rule's requirements for risk assessment and risk management. This tool is not intended to serve as legal advice or as recommendations based on a provider or professional's specific circumstances. We encourage providers, and professionals to seek expert advice when evaluating the use of this tool. Updated: August 18, 2023

Section 1, SRA Basics		
Threats & Vulnerabilities		
Inadequate Asset Tracking		
	Information disclosure (ePHI, proprietary, intellectual, or confidential)	Critical
	Disruption of business processes, information system function, and/or prolonged adversarial presence within information systems	High
	Unauthorized use of assets or changes to data within information systems	High
	Unauthorized installation of software or applications	Critical
	Loss, theft, or disruption of assets	Medium
	Improper operation/configuration of assets	High
Section 2, Security Policies		
Threats & Vulnerabilities		
No Threats and Vulnerabilities were selected or rated in Section 2.		
Section 3, Security & Workforce		
Threats & Vulnerabilities		
Failure to hold workforce members accountable for undesired actions		
	Insider carelessness causing disruption to computer systems	Medium
	Insider carelessness exposing ePHI to unauthorized persons or entities	Medium
	Lack of interest for protecting sensitive information	Medium
Section 4, Security & Data		
Threats & Vulnerabilities		
No Threats and Vulnerabilities were selected or rated in Section 4.		
Section 5, Security and the Practice		
Threats & Vulnerabilities		
Undocumented location of equipment or assets		
	Unconfirmed identity of connected physical devices/ equipment	Medium
	Unauthorized devices gaining access to the network	Medium
	Unconfirmed identity of connected devices/equipment	Low
	Exploitation of unsecured computer systems	High

Section 6, Security and Business Associates		
Threats & Vulnerabilities		
Failure to update or review business associate contracts		
	Contract termination due to expiration	Medium
	Provide sensitive information and ePHI without authorization	Medium
	Disruption of access to data due to contract dispute or lapse	Medium
	Inability to determine the criticality of access granted to third parties	Low
	Fines, litigation, and financial penalties from non-compliance	Medium

Section 7, Contingency Planning
Threats & Vulnerabilities
No Threats and Vulnerabilities were selected or rated in Section 7.

Areas for Review

Section 1, Q3. How often do you review and update your SRA?	
Answer	Periodically but not in response to operational changes and/or security incidents.
Education	An accurate and thorough security risk assessment should be reviewed and updated periodically, or in response to operational changes, or security incidents.
References	HIPAA: §164.308(a)(1)(ii)(A) NIST CSF: ID.RA, ID.AM, GV.OC, PR.DS, PR.PS, RS.MI HPH CPG: 1 HICP: TV1 - Practice #10

Section 3, Q18. Do you have a sanction policy to enforce security procedures?	
Answer	I don't know.
Education	Consider looking into whether your practice has a sanction policy. It is required that your practice be able to apply appropriate sanctions against workforce members who fail to comply with your practice's security policies and procedures.
References	HIPAA: §164.308(a)(1)(ii)(C) NIST CSF: PR.PS HPH CPG: N/A HICP: N/A

Section 4, Q2. How do you manage and control personnel access to ePHI, systems, and facilities?	
Answer	Other.

Education	Make sure your access control measures are effective and up-to-date. Implement a procedure for updating your log upon changes in the workforce to include access levels based on role within your practice. To meet the standard, any updates based on changes in the workforce should be verified by the security officer. Implement single sign-on systems that automatically manage access to all software and tools once users have signed onto the network. Such systems allow the organization to centrally maintain and monitor access.
References	HIPAA: §164.308(a)(3)(i) NIST CSF: PR.AT, PR.PS, PR.AA, PR.IRHPH CPG: 3, 6 HICP: TV1 - Practice #2, 3

Section 4, Q7. How do you make sure that your workforce's designated access to ePHI is logical, consistent, and appropriate?

Answer	Workforce members have a default level of access for their role, but exceptions are commonly granted.
Education	Review role-based access to determine how specific you can designate access for users, based on their roles. Implement and document procedures to ensure minimum necessary access is in place across the board to the extent reasonable and appropriate. If access exceptions are commonly granted, they should be documented and policies should be in place outlining the procedure for access exceptions. Tailor access for each user based on the user's specific workplace requirements. Most users require access to common systems, such as e-mail and file servers. Implementing tailored access is usually called provisioning.
References	HIPAA: §164.308(a)(3)(i) NIST CSF: PR.AT, PR.PS, DE.CMHPH CPG: 3, 8, 9 HICP: TV1 - Practice # 3,4

Section 4, Q24. Do you protect ePHI from unauthorized modification or destruction?

Answer	Yes. We have some procedures to protect the integrity of our ePHI but these may not be totally comprehensive.
Education	Implement policies and procedures to protect ePHI from unauthorized modification or destruction, such as user activity monitoring or data validation tools. Organizational policies should address all user interactions with sensitive data and reinforce the consequences of lost or compromised data.
References	HIPAA: §164.312(c)(1) NIST CSF: PR.DS HPH CPG: N/A HICP: TV1 - Practice # 4

Section 5, Q8. Do you have an authorized user who approves access levels within information systems and locations that use ePHI?

Answer	Yes. We have written procedures in place describing determination of user access levels to information systems, locations, and ePHI, but not detailing all of the variables described above.
Education	Consider assigning an authorized user to approve access levels with information systems and locations that contain and use ePHI. If this is determined to not be reasonable and appropriate, document the reason why and implement a compensating control. Describe cybersecurity roles and responsibilities throughout the organization, including who is responsible for implementing security practices and setting and establishing policy.

References	HIPAA: §164.308(a)(3)(ii)(A) NIST CSF: ID.AM, PR.MA, PR.PS HPH CPG: 6 HICP: TV1 - Practice # 2, 10

Section 5, Q22. Do you ensure access to ePHI is terminated when employment or other arrangements with the workforce member ends?

Answer	Yes. We have written procedures documenting termination or change of access to ePHI upon termination or change of employment, but not detailing all of the variables listed above.
Education	Changes to access to ePHI should be documented in the event of device recovery, deactivation of user access, and changes in access levels or privileges. Policy documentation should include details on how the process is completed. When an employee leaves your organization, ensure that procedures are executed to terminate the employee's access immediately. Prompt user termination prevents former employees from accessing patient data and other sensitive information after they have left the organization. This is very important for organizations that use cloud-based systems where access is based on credentials, rather than physical presence at a particular computer. Similarly, if an employee changes jobs within the organization, it is important to terminate access related to the employee's former position before granting access based on the requirements for the new position.
References	HIPAA: §164.308(a)(3)(ii)(C) NIST CSF: PR.AA, PR.IR, PR.PS HPH CPG: 6 HICP: TV1 - Practice # 3

Section 6, Q14. Does the organization require business associates and third-party vendors to implement security requirements more stringent than required in the HIPAA Rules?

Answer	No, contracts with vendors or BAs outline requirements to follow the HIPAA Rules as applicable to BAs without additional cybersecurity protocols.
Education	The HIPAA Rules require a covered entity to obtain satisfactory assurances from its business associate that it will appropriately safeguard PHI it receives or creates on behalf of the covered entity. Organizations could consider protocols within their business practice to include enhanced cybersecurity and supply chain requirements beyond those required by the HIPAA Rules that third parties can follow and how compliance with the requirements may be verified. Rules and protocols for information sharing between the organization and suppliers are detailed and included in contracts between the two.
References	HIPAA: N/A NIST CSF: GV.SC HPH CPG: 13 HICP: N/A

Section 6, Q15. How do you track and verify business associate and third-party vendor compliance to security policies and where are these policies documented?

Answer	The organization verifies business associate and third-party vendor status each year but does not perform evaluations.
Education	The organization could require business associates and third-party vendors to disclose cybersecurity features, functions, and known vulnerabilities of their products and services for the life of the product or the term of service. Contracts could require evidence of performing acceptable security practices through self-attestation, conformance to known standards, certifications, or inspections. Business associates and third-party vendors could be monitored to ensure they are fulfilling their security obligations throughout the relationship lifecycle.

References HIPAA: N/A NIST CSF: GV.SC HPH CPG: 13 HICP: N/A

Security Risk Analysis Tool

Application Version: 3.5

Remediation Report

12-24-2024

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Section 1, SRA Basics

Q3. How often do you review and update your SRA?

Answer: Periodically but not in response to operational changes and/or security incidents.
Education: An accurate and thorough security risk assessment should be reviewed and updated periodically, or in response to operational changes, or security incidents.

References
HIPAA: §164.308(a)(1)(ii)(A) NIST CSF: ID.RA, ID.AM, GV.OC, PR.DS, PR.PS, RS.MI HPH CPG: 1 HICP: TV1 - Practice #10

Remediation Activities:
Owner: Bryan Harper **Due Date:** 04-30-2025 **Date Completed:**

Section 2, Security Policies

Section 3, Security & Workforce

Q18. Do you have a sanction policy to enforce security procedures?

Answer: I don't know.
Education: Consider looking into whether your practice has a sanction policy. It is required that your practice be able to apply appropriate sanctions against workforce members who fail to comply with your practice's security policies and procedures.

References
HIPAA: §164.308(a)(1)(ii)(C) NIST CSF: PR.PS HPH CPG: N/A HICP: N/A

Remediation Activities:
Owner: Patty Dickson **Due Date:** 04-30-2025 **Date Completed:**

Section 4, Security & Data

Q2. How do you manage and control personnel access to ePHI, systems, and facilities?

Answer: Other.
Education: Make sure your access control measures are effective and up-to-date. Implement a procedure for updating your log upon changes in the workforce to include access levels based on role within your practice. To meet the standard, any updates based on changes in the workforce should be verified by the security officer. Implement single sign-on systems that automatically manage access to all software and tools once users have signed onto the network. Such systems allow the organization to centrally maintain and monitor access.

References
HIPAA: §164.308(a)(3)(i) NIST CSF: PR.AT, PR.PS, PR.AA, PR.IRHPH CPG: 3, 6 HICP: TV1 - Practice #2, 3

Remediation Activities:

Owner: **Due Date:** **Date Completed:**

Q7. How do you make sure that your workforce's designated access to ePHI is logical, consistent, and appropriate?

Answer: Workforce members have a default level of access for their role, but exceptions are commonly granted.
Education: Review role-based access to determine how specific you can designate access for users, based on their roles. Implement and document procedures to ensure minimum necessary access is in place across the board to the extent reasonable and appropriate. If access exceptions are commonly granted, they should be documented and policies should be in place outlining the procedure for access exceptions. Tailor access for each user based on the user's specific workplace requirements. Most users require access to common systems, such as e-mail and file servers. Implementing tailored access is usually called provisioning.

References
HIPAA: §164.308(a)(3)(i)
NIST CSF: PR.AT, PR.PS, DE.CMHPH CPG: 3, 8, 9 HICP: TV1 - Practice # 3,4

Remediation Activities:

Owner: **Due Date:** **Date Completed:**

Q24. Do you protect ePHI from unauthorized modification or destruction?

Answer: Yes. We have some procedures to protect the integrity of our ePHI but these may not be totally comprehensive.
Education: Implement policies and procedures to protect ePHI from unauthorized modification or destruction, such as user activity monitoring or data validation tools. Organizational policies should address all user interactions with sensitive data and reinforce the consequences of lost or compromised data.

References
HIPAA: §164.312(c)(1) NIST CSF: PR.DS HPH CPG: N/A HICP: TV1 - Practice # 4

Remediation Activities:

Owner: **Due Date:** **Date Completed:**

Section 5, Security and the Practice

Q8. Do you have an authorized user who approves access levels within information systems and locations that use ePHI?

Answer: Yes. We have written procedures in place describing determination of user access levels to information systems, locations, and ePHI, but not detailing all of the variables described above.
Education: Consider assigning an authorized user to approve access levels with information systems and locations that contain and use ePHI. If this is determined to not be reasonable and appropriate, document the reason why and implement a compensating control. Describe cybersecurity roles and responsibilities throughout the organization, including who is responsible for implementing security practices and setting and establishing policy.

References
HIPAA: §164.308(a)(3)(ii)(A)
NIST CSF: ID.AM, PR.MA, PR.PS HPH CPG: 6 HICP: TV1 - Practice # 2, 10

Remediation Activities:

Owner: **Due Date:** **Date Completed:**

Q22. Do you ensure access to ePHI is terminated when employment or other arrangements with the workforce member ends?

Answer: Yes. We have written procedures documenting termination or change of access to ePHI upon termination or change of employment, but not detailing all of the variables listed above.
Education: Changes to access to ePHI should be documented in the event of device recovery, deactivation of user access, and changes in access levels or privileges. Policy documentation should include details on how the process is completed. When an employee leaves your organization, ensure that procedures are executed to terminate the employee's access immediately. Prompt user termination prevents former employees from accessing patient data and other sensitive information after they have left the organization. This is very important for organizations that use cloud-based systems where access is based on credentials, rather than physical presence at a particular computer. Similarly, if an employee changes jobs within the organization, it is important to terminate access related to the employee's former position before granting access based on the requirements for the new position.

References
HIPAA: §164.308(a)(3)(ii)(C)
NIST CSF: PR.AA, PR.IR, PR.PS HPH CPG: 6 HICP: TV1 - Practice # 3

Remediation Activities:

Owner: **Due Date:** **Date Completed:**

Section 6, Security and Business Associates

Q14. Does the organization require business associates and third-party vendors to implement security requirements more stringent than required in the HIPAA Rules?

Answer: No, contracts with vendors or BAs outline requirements to follow the HIPAA Rules as applicable to BAs without additional cybersecurity protocols.
Education: The HIPAA Rules require a covered entity to obtain satisfactory assurances from its business associate that it will appropriately safeguard PHI it receives or creates on behalf of the covered entity. Organizations could consider protocols within their business practice to include enhanced cybersecurity and supply chain requirements beyond those required by the HIPAA Rules that third parties can follow and how compliance with the requirements may be verified. Rules and protocols for information sharing between the organization and suppliers are detailed and included in contracts between the two.

References
HIPAA: N/A NIST CSF: GV.SC
HPH CPG: 13 HICP: N/A

Remediation Activities:

Owner: **Due Date:** **Date Completed:**

Q15. How do you track and verify business associate and third-party vendor compliance to security policies and where are these policies documented?

Answer: The organization verifies business associate and third-party vendor status each year but does not perform evaluations.
Education: The organization could require business associates and third-party vendors to disclose cybersecurity features, functions, and known vulnerabilities of their products and services for the life of the product or the term of service. Contracts could require evidence of performing acceptable security practices through self-attestation, conformance to known standards, certifications, or inspections. Business associates and third-party vendors could be monitored to ensure they are fulfilling their security obligations throughout the relationship lifecycle.

References
HIPAA: N/A NIST CSF: GV.SC
HPH CPG: 13 HICP: N/A

Remediation Activities:

Owner:	Due Date:	Date Completed:

Section 7, Contingency Planning

ComplyAssistant

In early January 2025, Northern Inyo Healthcare District Compliance Department began the process of implementing ComplyAssistant.

The software allows for direct documentation of compliance with each standard in major compliance regulations. It provides the regulation, standards assessments, and areas to store documentation (policies, penetration testing, audits, etc.) that support our assessments. Additionally, this allows us to determine risk based on standardized metrics and create plans for risk mitigation. The current compliance percentages listed are based on the average of the completed metrics and not currently a reflection of overall compliance with the regulations during the implementation process.

The following pages contain four reports that demonstrate our starting point of data entry for each regulation. They also contain a list of all standards required to comply fully with each set of regulations.

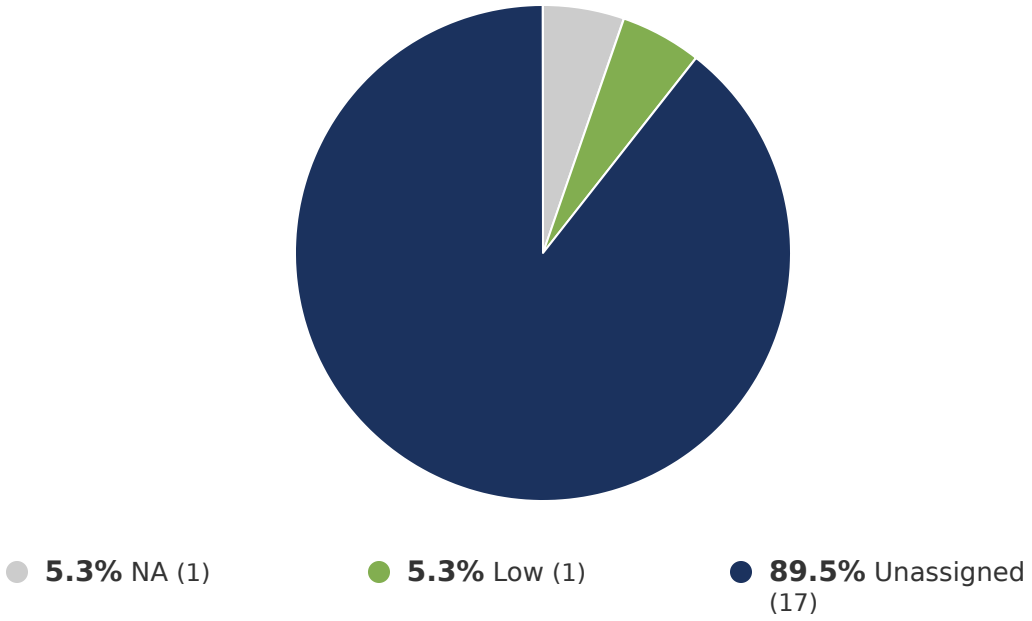
1. Federal Compliance Programs for Hospitals
2. Health Industry Cybersecurity Practices
3. HIPAA HITECH Security
4. HIPAA Privacy

HIPAA – Health Information Portability and Accountability Act of 1996
HITECH – Health Information Technology for Economic and Clinical Health Act of 2009

Regulation Management: Federal Compliance Program for Hospitals at Northern Inyo Healthcare District

Federal Compliance Program for Hospitals at Northern Inyo Healthcare District

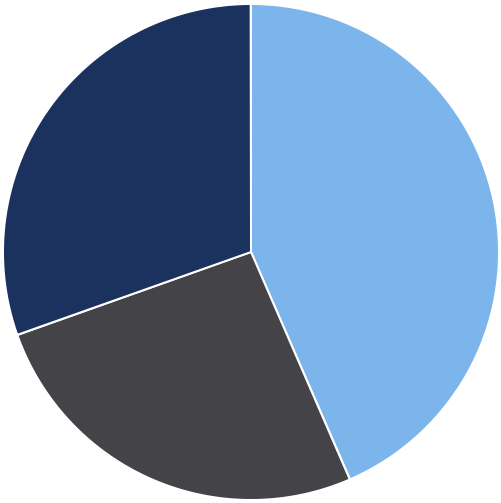
Average Risk: **Low (1)**



Risk Progress:

(2/19)

Average Compliance Level: 75%



- **52.6%** Established: Formal processes that are standardized across the organization have been established. The organization continuously evaluates risks and adapts processes in response to changes in its cybersecurity environment. (10)
- **31.6%** Developing: Formal processes are in development. The organization is evaluating risks and identifying appropriate protocols that are informed by the risk evaluation. (6)
- **36.8%** Unassigned (7)

Compliance Level Progress:

(12/19)

Federal Compliance Program for Hospitals - Rule Hierarchy: Scope

- **A. - Written Policies and Procedures**
  - **A.1. - Standards of Conduct**
  - **A.2. - Risk Areas**
  - **A.3 - Claim Development and Submission Process**
  - **A.4 - Test**
- **B -** Designation of a Compliance Officer
  - **B.1. - Designation of a Compliance Officer**

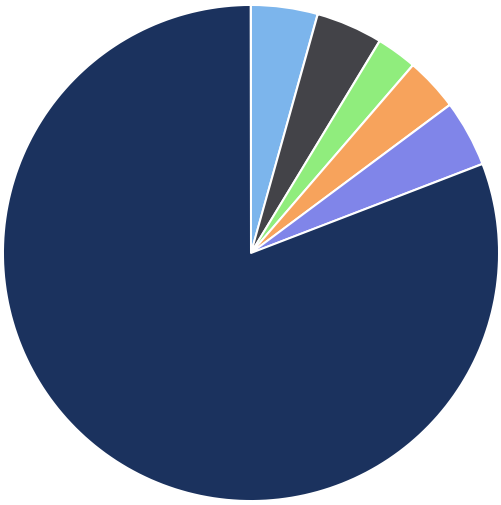
- **B.2 -** Designation of a Compliance Committee
- **C. - C. Conducting Effective Training and Education**
- **D. -** Developing Effective Lines of Communication
  - **D.1. -** Access to the Compliance Officer
  - **D.2. - Hotlines and Other forms of Communication**
- **E - Enforcing Standards Through Well Publicized Disciplinary Guidelines**
  - **E.1 -** Discipline Policy and Actions
  - **E.2. -** New Employee Policy
- **F. -** Auditing and Monitoring
- **G. -** Responding to Detected Offenses and Developing Corrective Action Initatives
  - **G.1. -** Violations and Investigations
  - **G.2. -** Reporting

Regulation Management: Health Industry Cybersecurity Practices 2023 (HICP) at Northern Inyo Healthcare District

Health Industry Cybersecurity Practices 2023 (HICP) at Northern Inyo Healthcare District

Average Risk: No Risk Assigned

Average Compliance Level: 88%



- **5.1%** Evaluated (5)
- **5.1%** Process in place (not documented) (5)
- **3.1%** Documented policies implemented (3)
- **4.1%** Documented procedures implemented (4)
- **5.1%** Implemented with Evidence (5)
- **94.9%** Unassigned (93)

Compliance Level Progress:

(5/98)

Health Industry Cybersecurity Practices 2023 (HICP) - Rule Hierarchy:

Scope

- **S -** Small
  - **1.S - Email Protection Systems**
    - **1.S.A - Email System Configuration**
    - **1.S.B - Education**

- **1.S.C -** Phishing Simulations

2.S - Endpoint Protection Systems

- **2.S.A - Basic Endpoint Protection Controls**

3.S - Access Management

- **3.S.A - Basic Access Management**

4.S - Data Protection and Loss Prevention

- **4.S.A -** Policies
- **4.S.B -** Procedures
- **4.S.C -** Education

5.S - Asset Management

- **5.S.A -** Inventory
- **5.S.B -** Procurement
- **5.S.C -** Decommissioning

6.S - Network Management

- **6.S.A -** Network Segmentation
- **6.S.B -** Physical Security and Guest Access
- **6.S.C -** Intrusion Prevention

7.S - Vulnerability Management

- **7.S.A -** Vulnerability Management

8.S - Incident Response

- **8.S.A -** Incident Response
- **8.S.B -** ISAC/ISAO Participation

9.S - Network Connected Medical Devices

- **9.S.A -** Medical Device Security

10.S - Cybersecurity Oversight and Governance

- **10.S.A -** Policies
- **10.S.B -** Cybersecurity Risk Assessment and Management
- **10.S.C -** Security Awareness and Training
- **10.S.D -** Cyber Insurance

M - Medium

1.M - Email Protection Systems

- **1.M.A -** Basic Email Protection Controls
- **1.M.B -** MFA for Remote Email Access

1.M.C - Email Encryption

1.M.D - Workforce Education

2.M - Endpoint Protection Systems

2.M.A - Basic Endpoint Protection Controls

3.M - Access Management

3.M.A - Identity

3.M.B - Provisioning, Transfers, and De-provisioning Procedures

3.M.C - Authentication

3.M.D - Multi-Factor Authentication for Remote Access

4.M - Data Protection and Loss Prevention

4.M.A - Classification of Data

4.M.B - Data Use Procedures

4.M.C - Data Security

4.M.D - Backup Strategies

4.M.E - Data Loss Prevention (DLP)

5.M - Asset Management

5.M.A - Inventory of Endpoints and Servers

5.M.B - Procurement

5.M.C - Secure Storage for Inactive Devices

5.M.D - Decommissioning Assets

6.M - Network Management

6.M.A - Network Profiles and Firewalls

6.M.B - Network Segmentation

6.M.C - Intrusion Prevention Systems

6.M.D - Web Proxy Protection

6.M.E - Physical Security of Network Devices

7.M - Vulnerability Management

7.M.A - Host/Server Based Scanning

7.M.B - Web Application Scanning

7.M.C - System Placement and Data Classification

7.M.D - Patch Management, Configuration Management, Change Management

8.M - Incident Response

8.M.A - Security Operations Center

8.M.B - Incident Response

8.M.C - Information Sharing and ISACs/ISAOs

9.M - Network Connected Medical Devices

9.M.A - Asset Management

9.M.B - Endpoint Protections

9.M.C - Identity and Access Management

9.M.D - Network Management

9.M.E - Vulnerability Management

9.M.F - Contacting the FDA

10.M - Cybersecurity Oversight and Governance

10.M.A - Policies

10.M.B - Cybersecurity Risk Assessment and Management

10.M.C - Security Awareness and Training

L - Large

1.L - Email Protection Systems

1.L.A - Advanced and Next Generation Tooling

1.L.B - Digital Signatures

1.L.C - Analytics Driven Education

2.L - Endpoint Protection Systems

2.L.A - Automate the Provisioning of Endpoints

2.L.B - Mobile Device Management

2.L.C - Host Based Intrusion Detection/Prevention Systems

2.L.D - Endpoint Detection Response

2.L.E - Application Whitelisting

2.L.F - Micro-segmentation/virtualization strategies

3.L - Access Management

3.L.A - Federated Identity Management

3.L.B - Authorization

3.L.C - Access Governance

3.L.D - Single-Sign On (SSO)

4.L - Data Protection and Loss Prevention

4.L.A - Advanced Data Loss Prevention

4.L.B - Mapping of Data Flows

5.L - Asset Management

- **5.L.A -** Automated Discovery and Maintenance
- **5.L.B -** Integration with Network Access Control

6.L - Network Management

- **6.L.A -** Additional Network Segmentation
- **6.L.B -** Command and Control Monitoring of Perimeter
- **6.L.C -** Anomalous Network Monitoring and Analytics
- **6.L.D -** Network Based Sandboxing/Malware Execution
- **6.L.E -** Network Access Control (NAC)

7.L - Vulnerability Management

- **7.L.A -** Penetration Testing
- **7.L.B -** Remediation Planning
- **7.L.C -** Attack Simulation

8.L - Incident Response

- **8.L.A -** Advanced Security Operations Center
- **8.L.B -** Advanced Information Sharing
- **8.L.C -** Incident Response Orchestration
- **8.L.D -** Baseline Network Traffic
- **8.L.E -** User Behavior Analytics
- **8.L.F -** Deception Technologies

9.L - Medical Device Security

- **9.L.A -** Security Operations and Incident Response
- **9.L.B -** Procurement and Security Evaluations

10.L - Cybersecurity Oversight and Governance

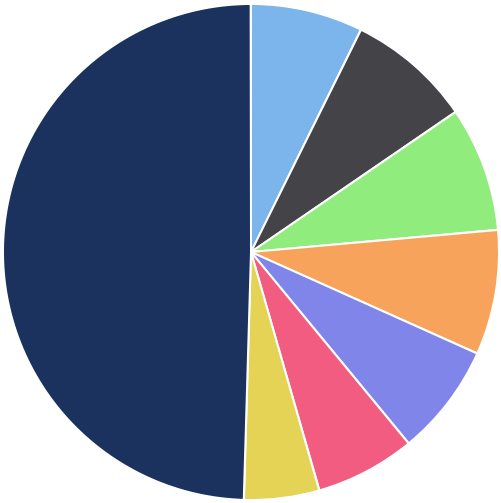
- **10.L.A - Cyber Insurance**

Regulation Management: HIPAA / HITECH Security at Northern Inyo Healthcare District

HIPAA / HITECH Security at Northern Inyo Healthcare District

Average Risk: No Risk Assigned

Average Compliance Level: 89%



- **12.7%** Operational controls and processes indicate a reasonable level of due diligence for this standard/implementation specification. (9)
- **14.1%** Policies are in place to support the documented operational controls and processes, and overall requirements of this standard/implementation specification. (10)
- **14.1%** Procedures are in place to support the documented operational controls and processes, and overall requirements of this standard/implementation specification. (10)
- **14.1%** Policy(ies) and procedure(s) are reviewed and updated (if necessary) on a reasonable periodic basis (e.g. annual, organization, technical and/or regulatory changes). (10)
- **12.7%** Periodic audits are performed (if appropriate) as specified in the policy(ies) and procedure(s). (9)
- **11.3%** This standard / implementation specification is included in the security management workforce training program. (8)
- **8.5%** Evidence of operational compliance is available to support the documented controls and processes; policies and procedures; and overall requirements of this standard/implementation specification. (6)
- **85.9%** Unassigned (61)

Compliance Level Progress:

(10/71)

HIPAA / HITECH Security - Rule Hierarchy: Scope

- **Part 164 - Security and Privacy**
  - **164 - Subpart C -** Security Standards for the Protection of Electronic Protected Health Information
    - **164.308 -** Administrative safeguards.
      - **164.308(a)(1)(i) -** Security Management Process
        - **164.308(a)(1)(ii)(A) - Risk Analysis (Required)**
        - **164.308(a)(1)(ii)(B) - Risk Management (Required)**
        - **164.308(a)(1)(ii)(C) - Sanction Policy (Required)**
        - **164.308(a)(1)(ii)(D) - Information System Activity Review (Required)**
      - **164.308(a)(2) - Assigned security responsibility.**
      - **164.308(a)(3)(i) - Workforce security**
        - **164.308(a)(3)(ii)(A) - Authorization and/or supervision(Addressable)**
        - **164.308(a)(3)(ii)(B) - Workforce clearance procedure (Addressable)**
        - **164.308(a)(3)(ii)(C) - Termination procedures (Addressable)**
      - **164.308(a)(4)(i) -** Information access management.
        - **164.308(a)(4)(ii)(A) -** Isolating health care clearinghouse functions (Required)
        - **164.308(a)(4)(ii)(B) - Access authorization (Addressable)**
        - **164.308(a)(4)(ii)(C) -** Access establishment and modification (Addressable)
      - **164.308(a)(5)(i) - Security awareness and training.**
        - **164.308(a)(5)(ii)(A) - Security reminders (Addressable)**
        - **164.308(a)(5)(ii)(B) - Protection from malicious software (Addressable)**
        - **164.308(a)(5)(ii)(C) - Log-in monitoring (Addressable)**
        - **164.308(a)(5)(ii)(D) - Password management (Addressable)**
      - **164.308(a)(6)(i) - Security incident procedures.**
        - **164.308(a)(6)(ii) - Response and Reporting (Required)**
      - **164.308(a)(7)(i) - Contingency plan.**
        - **164.308(a)(7)(ii)(A) - Data backup plan (Required)**
        - **164.308(a)(7)(ii)(B) -** Disaster recovery plan (Required)
        - **164.308(a)(7)(ii)(C) - Emergency mode operation plan (Required)**
        - **164.308(a)(7)(ii)(D) - Testing and revision procedures (Addressable)**

- **164.308(a)(7)(ii)(E) -** Applications and data criticality analysis (Addressable)
- **164.308(a)(8) - Evaluation.**
- **164.308(b)(1) - Business associate contracts and other arrangements.**
- **164.308(b)(3) - Written contract or other arrangement (Required)**
- **164.310 -** Physical safeguards.
- **164.310(a)(1) - Facility access controls.**
- **164.310(a)(2)(i) - Contingency operations (Addressable)**
- **164.310(a)(2)(ii) - Facility security plan (Addressable)**
- **164.310(a)(2)(iii) - Access control and validation procedures (Addressable)**
- **164.310(a)(2)(iv) - Maintenance records (Addressable)**
- **164.310(b) - Workstation use.**
- **164.310(c) - Workstation security.**
- **164.310(d)(1) - Device and media controls.**
- **164.310(d)(2)(i) -** Disposal (Required)
- **164.310(d)(2)(ii) - Media re-use (Required)**
- **164.310(d)(2)(iii) - Accountability (Addressable)**
- **164.310(d)(2)(iv) - Data backup and storage (Addressable)**
- **164.312 - Technical safeguards.**
- **164.312(a)(1) - Access control.**
- **164.312(a)(2)(i) - Unique user identification (Required)**
- **164.312(a)(2)(ii) - Emergency access procedure (Required)**
- **164.312(a)(2)(iii) - Automatic logoff (Addressable)**
- **164.312(a)(2)(iv) - Encryption and decryption (Addressable)**
- **164.312(b) - Audit controls.**
- **164.312(c)(1) - Integrity.**
- **164.312(c)(2) - Mechanism to authenticate electronic protected health information (Addressable)**
- **164.312(d) - Person or entity authentication.**
- **164.312(e)(1) - Transmission security.**
- **164.312(e)(2)(i) -** Integrity controls (Addressable)
- **164.312(e)(2)(ii) - Encryption (Addressable)**
- **164.314 -** Organizational requirements.
- **164.314(a)(1) -** Business associate contracts or other arrangements.

164.314(a)(2)(i) - Business associate contracts (Required)

164.314(a)(2)(ii) - Other arrangements (Required)

164.314(a)(2)(iii) - Business associate contracts with subcontractors. (Required)

164.314(b)(1) - Requirements for group health plans.

164.314(b)(2)(i)-(iv) - Requirements for group health plans. (Required)

164.316 - Policies and procedures and documentation requirements.

164.316(a) - Policies and Procedures.

164.316(b)(1) - Documentation.

164.316(b)(2)(i) - Time limit (Required)

164.316(b)(2)(ii) - Availability (Required)

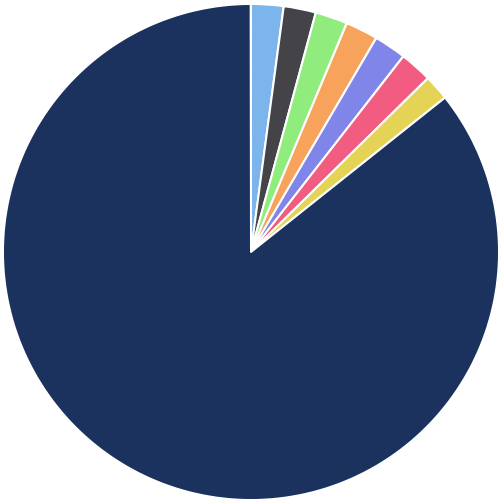
164.316(b)(2)(iii) - Updates (Required)

Regulation Management: HIPAA Privacy at Northern Inyo Healthcare District

HIPAA Privacy at Northern Inyo Healthcare District

Average Risk: No Risk Assigned

Average Compliance Level: 97%



- **2.4%** Operational controls and processes indicate a reasonable level of due diligence for this standard/implementation specification. (5)
- **2.4%** Policies are in place to support the documented operational controls and processes, and overall requirements of this standard/implementation specification. (5)
- **2.4%** Procedures are in place to support the documented operational controls and processes, and overall requirements of this standard/implementation specification. (5)
- **2.4%** Policy(ies) and procedure(s) are reviewed and updated (if necessary) on a reasonable periodic basis (e.g. annual, organization, technical and/or regulatory changes). (5)
- **2.4%** Periodic audits are performed (if appropriate) as specified in the policy(ies) and procedure(s). (5)
- **2.4%** Evidence of operational compliance is available to support the documented controls and processes; policies and procedures; and overall requirements of this standard/implementation specification. (5)
- **1.9%** This standard / implementation specification is included in the security management workforce training program. (4)
- **97.6%** Unassigned (207)

Compliance Level Progress:

(5/212)

HIPAA Privacy - Rule Hierarchy:	Scope
164 - Security and Privacy	
164 - Subpart E - Standards for Privacy of Individually Identifiable Health Information	
§ 164.501 - Definitions	
§ 164.500 - Applicability	
§ 164.502 - Uses and Disclosures of Protected Health Information: General Rules.	
§ 164.502(a) - Permitted Uses and Disclosures	
§ 164.502(a)(1) - Permitted uses and disclosures. A covered entity is permitted to use or disclose protected health information	
§ 164.502(a)(2) - Required disclosures. A covered entity is required to disclose protected health information	
§ 164.502(b) - Minimum Necessary	
§ 164.502(c) - Uses and Disclosures Subject to Restrictions	
§ 164.502(d) - Uses and Disclosures of De-identified PHI	
§ 164.502(e)(1) - Disclosures to Business Associates	
§ 164.502(e)(2) - Implementation Specifications: Documentation	
§ 164.502(f) - Deceased Individuals	
§ 164.502(g)(1) - Personal Representatives	
§ 164.502(g)(2) - Implementation Specification: Adults and Emancipated Minors	
§ 164.502(g)(3) - Implementation Specification: Unemancipated Minors	
§ 164.502(g)(4) - Implementation Specification: Deceased Individuals	
§ 164.502(g)(5) - Implementation Specification: Abuse, Neglect and Endangerment	
§ 164.502(h) - Confidential Communications	
§ 164.502(i) - Uses and Disclosures Consistent with Notice	
§ 164.502(j) - Disclosures by Whistleblowers and Workforce Member Crime Victims	
§ 164.502(j)(1) - Implementation Specification: Disclosures by Whistleblowers	
§ 164.502(j)(2) - Implementation Specification: Disclosures by Workforce Members Who are Victims of a Crime	
§ 164.504 - Uses and Disclosures: Organizational Requirements	
§ 164.504(a) - Definitions	
§ 164.504(b)-(d) - Reserved	
§ 164.504(e)(1) - Business Associate Contracts	
§ 164.504(e)(2) - Implementation Specifications: Business Associate Contracts	

- **§ 164.504(e)(3) -** Implementation Specifications: Other Arrangements
- **§ 164.504(e)(4) -** Implementation Specifications: Other Requirements for Contracts and Other Arrangements
- **§ 164.504(e)(5) -** Implementation Specifications: Business Associate Contracts with Subcontractors
- **§ 164.504(f)(1) -** Requirements for Group Health Plans
- **§ 164.504(f)(2) -** Implementation Specifications: Plan Documents
- **§ 164.504(f)(3) -** Implementation Specifications: Uses and Disclosures by Group Health Plans
- **§ 164.504(g) -** Requirements for a Covered Entity with Multiple Covered Functions
- **§ 164.504(g)(1) -** Implementation Specification: Standards and Requirements
- **§ 164.504(g)(2) -** Implementation Specification: Uses and Disclosures
- **§ 164.506 -** Uses and Disclosures to Carry Out Treatment, Payment or Health Care Operations
- **§ 164.506(a) -** Permitted Uses and Disclosures
- **§ 164.506(b) -** Consent for Uses and Disclosures Permitted
- **§ 164.506(b)(1) -** Implementation Specification: Consent for Uses
- **§ 164.506(b)(2) -** Implementation Specification: Disclosures Permitted
- **§ 164.506(c) -** Implementation Specifications: Treatment, Payment or Health Care Operations
- **§ 164.508 -** Uses and Dislosures for which an Authorization is Required
- **§ 164.508(a) -** Authorizations for Uses and Disclosures
- **§ 164.508(a)(1) -** Implementation Specification: Authorization Required: General Rule
- **§ 164.508(a)(2) -** Implementation Specification: Authorization Required: Psychotherapy Notes
- **§ 164.508(a)(3) -** Implementation Specification: Authorization Required: Marketing
- **§ 164.508(a)(4) -** Implementation Specification: Authorization Required: Sale of Protected Health Information
- **§ 164.508(a)(5) -** Implementation Specification: Reproductive health care
  - **§ 164.508(a)(5)(A) -** Prohibition.
  - **§ 164.508(a)(5)(B) -** Rule of applicability.
  - **§ 164.508(a)(5)(C) -** Presumption.
  - **§ 164.508(a)(5)(D) -** Scope.
- **§ 164.508(b) -** Implementation Specifications: General Authorization Requirements
  - **§ 164.508(b)(1) -** Sub Implementation Specification: Valid Authorizations
  - **§ 164.508(b)(2) -** Sub Implementation Specification: Defective Authorizations
  - **§ 164.508(b)(3) -** Sub Implementation Specification: Compound Authorizations

- **§ 164.508(b)(4) -** Sub Implementation Specification: Prohibition on Conditioning of Authorizations
- **§ 164.508(b)(5) -** Sub Implementation Specification: Revocation of Authorizations
- **§ 164.508(b)(6) -** Sub Implementation Specification: Documentation
- **§ 164.508(c) -** Implementation Specifications: Core Elements and Requirements
- **§ 164.508(c)(1) -** Sub Implementation Specification: Core Elements
- **§ 164.510 -** Uses and Disclosures Requiring Opportunity to Agree or Object
- **§ 164.510(a) -** Use and Disclosure for Facility Directories
- **§ 164.510(a)(1) -** Implementation Specification: Permitted Uses and Disclosure
- **§ 164.510(a)(2) -** Implementation Specification: Opportunity to Object
- **§ 164.510(a)(3) -** Implementation Specification: Emergency Circumstances
- **§ 164.510(b) -** Uses and Disclosures for Involvement in Individual's Care and for Notification Purposes
- **§ 164.510(b)(1) -** Implementation Specification: Permitted Uses and Disclosures
- **§ 164.510(b)(2) -** Implementation Specification: Uses and Disclosures With the Individual Present
- **§ 164.510(b)(3) -** Implementation Specification: Limited Uses and Disclosures When the Individual is Not Present
- **§ 164.510(b)(4) -** Implementation Specification: Use and Disclosures for Disaster Relief Purposes
- **§ 164.510(b)(5) -** Implementation Specification: Uses and Disclosures When the Individual is Deceased
- **§ 164.509 -** Uses and Disclosures for Which an Attestation is Required.
- **§ 164.509(a) -** Attestations for certain uses and disclosures of protected health information to persons other than covered entities or business associates.
- **§ 164.509(b) -** Implementation specification: General requirements
- **§ 164.509(b)(1) -** Valid attestations.
- **§ 164.509(b)(2) -** Defective attestations.
- **§ 164.509(b)(3) -** Compound attestation.
- **§ 164.509(c) -** Implementation specifications: Content requirements and other obligations
- **§ 164.509(c)(1) -** Required elements.
- **§ 164.509(c)(2) -** Plain language requirement.
- **§ 164.509(d) -** Implementation Specification: Material misrepresentations
- **§ 164.512 -** Uses and Disclosures for which an Authorization Or Opportunity to Agree/Object is not Required

- **§ 164.512(a) -** Uses and Disclosures Required by Law
  - **§ 164.512(a)(1) -** Implementation Specification: Uses and Disclosures
- **§ 164.512(b) -** Uses and Disclosures for Public Health Activities
  - **§ 164.512(b)(1) -** Implementation Specification: Permitted Disclosures
- **§ 164.512(c) -** Disclosures about Victims of Abuse, Neglect or Domestic Violence
  - **§ 164.512(c)(1) -** Implementation Specification: Permitted Disclosures
  - **§ 164.512(c)(2) -** Implementation Specification: Informing the Individual
- **§ 164.512(d) -** Uses and Disclosures for Health Oversight Activities
  - **§ 164.512(d)(1) -** Implementation Specification: Permitted Disclosures
  - **§ 164.512(d)(2) -** Implementation Specification: Exception to Health Oversight Activities
- **§ 164.512(e) -** Disclosures for Judicial and Administrative Proceedings
  - **§ 164.512(e)(1) -** Implementation Specification: Permitted Disclosures
- **§ 164.512(f) -** Disclosures for Law Enforcement Purposes
  - **§ 164.512(f)(1) -** Implementation Specification: Permitted Disclosures: Pursuant to Process and as Otherwise Required by Law
  - **§ 164.512(f)(2) -** Implementation Specification: Permitted Disclosures: Limited Information for Identification and Location Purposes
  - **§ 164.512(f)(3) -** Implementation Specification: Permitted Disclosure: Victims of a Crime
  - **§ 164.512(f)(4) -** Implementation Specification: Permitted Disclosure: Decedents
  - **§ 164.512(f)(5) -** Implementation Specification: Permitted Disclosure: Crime on Premises
  - **§ 164.512(f)(6) -** Implementation Specification: Permitted Disclosure: Reporting Crime in Emergencies
- **§ 164.512(g) -** Uses and Disclosures about Decedents
- **§ 164.512(h) -** Uses and Disclosures for Organ, Eye and Tissue Donation Purposes
- **§ 164.512(i) -** Uses and Disclosures for Research Purposes
  - **§ 164.512(i)(1) -** Implementation Specification: Permitted Uses and Disclosures
  - **§ 164.512(i)(2) -** Implementation Specification: Documentation of Waiver Approval
- **§ 164.512(j) -** Uses and Disclosures to Avert a Serious Threat to Health or Safety
  - **§ 164.512(j)(1) -** Implementation Specification: Permitted Disclosures
- **§ 164.512(k) -** Uses and Disclosures for Specialized Government Functions
  - **§ 164.512(k)(1) -** Implementation Specification: Military and Veterans Activities
  - **§ 164.512(k)(2) -** Implementation Specification: National Security and Intelligence Activities
  - **§ 164.512(k)(3) -** Implementation Specification: Protective Services for the President and Others

- **§ 164.512(k)(4) -** Implementation Specification: Medical Suitability Determinations
- **§ 164.512(k)(5) -** Implementation Specification: Correctional Institutions and Other Law Enforcement Custodial Situations
- **§ 164.512(l) -** Disclosures for Workers' Compensation
- **§ 164.514 -** Other Requirements Relating to Uses and Disclosures of Protected Health Information
- **§ 164.514(a) -** De-Identification of Protected Health Information
- **§ 164.514(b) -** Implementation Specifications: Requirements for De-identification of Protected Health Information
  - **§ 164.514(b)(1) -** Sub Implementation Specification: Determining and Documenting Risk
  - **§ 164.514(b)(2) -** Sub Implementation Specification: Identifiers of the Individual
- **§ 164.514(c) -** Implementation Specifications: Re-Identification
- **§ 164.514(d)(1) -** Minimum Necessary Requirements
- **§ 164.514(d)(2) -** Implementation Specifications: Minimum Necessary Uses of Protected Health Information
- **§ 164.514(d)(3) -** Implementation Specification: MInimum Necessary Disclosures of Protected Health Information
- **§ 164.514(d)(4) -** Implementation Specifications: Minimum Necessary Requests for Protected Health Information
- **§ 164.514(d)(5) -** Implementation Specification: Other Content Requirement
- **§ 164.514(e)(1) -** Limited Data Set
- **§ 164.514(e)(2) -** Implementation Specification: Limited Data Set
- **§ 164.514(e)(3) -** Implementation Specification: Permitted purposes for uses and disclosures
- **§ 164.514(e)(4) -** Implementation Specifications: Data Use Agreement
- **§ 164.514(f)(1) -** Uses and Disclosures for Fundraising
- **§ 164.514(f)(2) -** Implementation Specifications: Fundraising Requirements
- **§ 164.514(g) -** Uses and Disclosures for Underwriting and Related Purposes
- **§ 164.514(h)(1) -** Verification Requirements
- **§ 164.514(h)(2) -** Implementation Specifications: Verification
- **§ 164.520 -** Notice of Privacy Practices for Protected Health Information
- **§ 164.520(a) -** Notice of Privacy Practices
- **§ 164.520(a)(1) -** Implementation Specification: Right to Notice
- **§ 164.520(a)(2) -** Implementation Specification: Notice requirements for covered entities creating or maintaining records subject to 42 U.S.C. 290dd-2.
- **§ 164.520(b) -** Implementation Specifications: Content of Notice
  - **§ 164.520(b)(1) -** Sub Implementation Specification: Required Elements

- **§ 164.520(c) -** Implementation Specifications: Provision of Notice
  - **§ 164.520(c)(1) -** Sub Implementation Specification: Specific Requirements for Health Plans
  - **§ 164.520(c)(2) -** Sub Implementation Specification: Specific Requirements for Certain Covered Health Care Providers
  - **§ 164.520(c)(3) -** Sub Implementation Specification: Specific Requirements for Electronic Notice
- **§ 164.520(d) -** Implementation Specifications: Joint Notice by Separate Covered Entities
  - **§ 164.520(d)(1) -** Sub Implementation Specification: Terms of the Joint Notice
- **§ 164.520(e) -** Implementation Specifications: Documentation

§ 164.522 - Right to Request Privacy Protection for Protected Health Information

- **§ 164.522(a)(1) -** Right of an Individual to Request Restriction of Uses and Disclosures
- **§ 164.522(a)(2) -** Implementation Specifications: Terminating a Restriction
- **§ 164.522(a)(3) -** Implementation Specification: Documentation
- **§ 164.522(b)(1) -** Confidential Communications Requirements
- **§ 164.522(b)(2) -** Implementation Specifications: Conditions on Providing Confidential Communications

§ 164.524 - Access of Individuals to Protected Health Information

- **§ 164.524(a) -** Access to Protected Health Information
- **§ 164.524(a)(1) -** Implementation Specification: Right of Access
- **§ 164.524(a)(2) -** Implementation Specification: Unreviewable Grounds for Denial
- **§ 164.524(a)(3) -** Implementation Specification: Reviewable Grounds for Denial
- **§ 164.524(a)(4) -** Implementation Specification: Review of a Denial of Access
- **§ 164.524(b) -** Implementation Specifications: Requests for Access and Timely Action
  - **§ 164.524(b)(2) -** Sub Implementation Specification: Timely Action by the Covered Entity
- **§ 164.524(c) -** Implementation Specifications: Provision of Access.
  - **§ 164.524(c)(2) -** Sub Implementation Specification: Form of Access Requested
  - **§ 164.524(c)(4) -** Sub Implementation Specification: Fees
- **§ 164.524(d) -** Implementation Specifications: Denial of Access
  - **§ 164.524(d)(2) -** Sub Implementation Specification: Denial
  - **§ 164.524(d)(4) -** Sub Implementation Specification: Review of Denial Requested
- **§ 164.524(e) -** Implementation Specification: Documentation

§ 164.526 - Amendment of Protected Health Information

- **§ 164.526(a) -** Amendment of Protected Health Information

- **§ 164.526(a)(1) -** Implementation Specification: Right to Amend
- **§ 164.526(a)(2) -** Implementation Specification: Denial of Amendment
- **§ 164.526(b) -** Implementation Specifications: Requests for Amendment and Timely Action
- **§ 164.526(c) -** Implementation Specifications: Accepting the Amendment
- **§ 164.526(d) -** Implementation Specifications: Denying the Amendment
  - **§ 164.526(d)(1) -** Sub Implementation Specification: Denial
- **§ 164.526(e) -** Implementation Specification: Actions on Notices of Amendment
- **§ 164.526(f) -** Implementation Specification: Documentation

§ 164.528 - Accounting of Disclosures of Protected Health Information

- **§ 164.528(a) -** Right to an Accounting of Disclosures
  - **§ 164.528(a)(1) -** Implementation Specification: Conditions on Right to an Accounting of Disclosures
- **§ 164.528(b) -** Implementation Specifications: Content of the Accounting
- **§ 164.528(c) -** Implementation Specifications: Provision of the Accounting
- **§ 164.528(d) -** Implementation Specification: Documentation

§ 164.530 - Administrative Requirements

- **§ 164.530(a)(1) -** Personnel Designations
  - **§ 164.530(a)(2) -** Implementation Specification: Personnel Designations
- **§ 164.530(b)(1) -** Training
  - **§ 164.530(b)(2) -** Implementation Specifications: Training
- **§ 164.530(c)(1) -** Safeguards
  - **§ 164.530(c)(2) -** Implementation Specification: Safeguards
- **§ 164.530(d)(1) -** Complaints to the Covered Entity
  - **§ 164.530(d)(2) -** Implementation Specification: Documentation of Complaints
- **§ 164.530(e)(1) -** Sanctions
  - **§ 164.530(e)(2) -** Implementation Specification: Documentation
- **§ 164.530(f) -** Mitigation
- **§ 164.530(g) -** Refraining from Intimidating or Retaliatory Acts
- **§ 164.530(h) -** Waiver of Rights
- **§ 164.530(i)(1) -** Policies and Procedures
- **§ 164.530(i)(2) -** Changes to Policies and Procedures
  - **§ 164.530(i)(3) -** Implementation Specification: Changes in Law

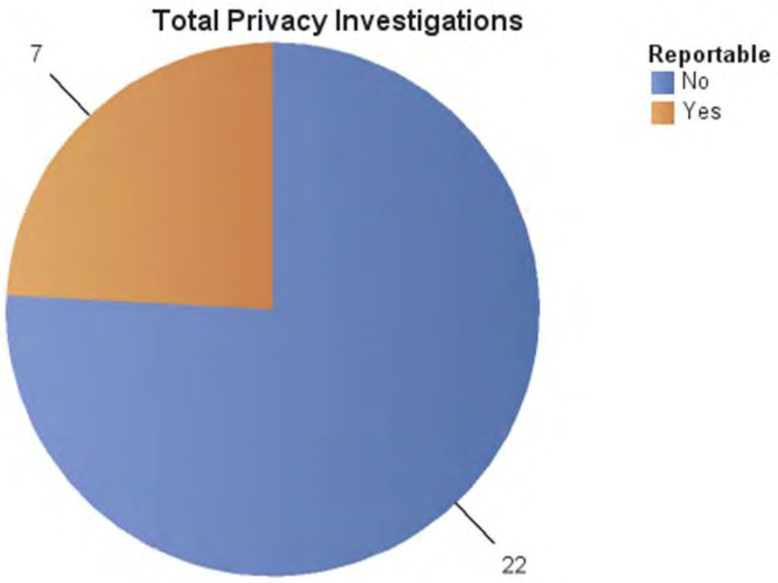
- **§ 164.530(i)(4) -** Implementation Specification: Changes to Privacy Practices Stated in the Notice
- **§ 164.530(i)(5) -** Implementation Specification: Changes to other Policies and Procedures
- **§ 164.530(j)(1) -** Documentation
- **§ 164.530(j)(2) -** Implementation Specification: Retention Period
- **§ 164.530(k) -** Group Health Plans
- **§ 164.532 -** Transition Provisions
- **§ 164.534 -** Compliance Dates for Initial Implementation of the Privacy Standards

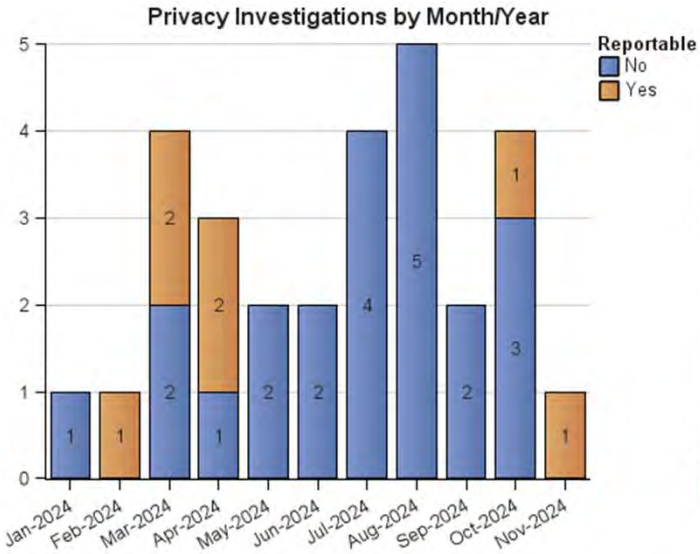
No.	Item	Reference	Comments
Compliance Oversight and Management			
1.	Review and update charters and policies related to the duties and responsibilities of the Compliance Committees.	NIHD Compliance Program (p.17)	Due CY2025 Q1
2.	Develop and deliver the annual briefing and training for the Board on changes in the regulatory and legal environment, along with their duties and responsibilities in oversight of the Compliance Program.	NIHD Compliance Program (p.17)	Due CY2025 Q2
3.	Develop a Compliance Department budget to ensure sufficient staff and other resources to fully meet obligations and responsibilities.		Due CY2025 Q2
4.	District Policy and Procedure management		Due CY2025 Q2
5.	Review, distribute, and assist leaders with new regulatory updates and guidance	Implemented YouCompli software December 2025	Ongoing
Written Compliance Guidance			
6.	Audit of required Compliance related policies.		Policies for Compliance are in the review process as of Jan 2025
7.	Annual review of Code of Conduct to ensure that it currently meets the needs of the organization and is consistent with current policies. (Note: Less than 12 pages, 10 grade reading level or below)		Overdue – was due in CY2024 Q3
8.	Verify that the Code of Conduct has been disseminated to all new employees and workforce.		Ongoing in conjunction with HR. Current to date.
Compliance Education and Training			
9.	Verify all workforce receive compliance training and that documentation exists to support results. Report results to Compliance and Business Ethics Committee.	Compliance and Business Ethics Committee has not met since 2023. Information reported to Executives and Board as needed.	Ongoing in conjunction with HR. Current to date.
10.	Ensure all claims processing staff receive specialized training programs on proper documentation and coding.		External companies providing coding and claims processing services. New regulatory changes discussed at Billing and Coding Compliance Committee (BCCC

11.	Review and assess role-based access for EHR (electronic health record) and partner programs. Implement/evaluate standardized process to assign role-based access.		Ongoing. Well-developed process and procedure for Role-based access.
12.	Compliance training programs: fraud and abuse laws, coding requirements, claim development and submission processes, general prohibitions on paying or receiving remuneration to induce referrals and other current legal standards.		Training completed at orientation, via policy/procedure review, Learning Management System, email, in-person, departmental meetings, and "Just-in-time training"
Compliance Communication			
13.	Review unusual occurrence report trends and compliance concerns. Prepare summary report for Compliance Committee on types of issues reported and resolution		Annual and quarterly reports submitted to appropriate committees, Executives, and Board of Directors.
14.	Develop a report that evidences prompt documenting, processing, and resolution of complaints and allegations received by the Compliance Department.	Submitted to Executives and Board of Directors in quarterly and Annual Board reports	Current through January 2025
15.	Document test and review of Compliance Hotline.		Completed January 2025
16.	Physically verify Compliance hotline posters appear prominently on employee boards in work areas.		Completed January 2025
Compliance Enforcement and Sanction Screening			
17.	Verify that sanction screening of all employees/workforce and others engaged by NIHD against Office of Inspector General (OIG) List of Excluded Individuals and Entities has been performed in a timely manner, and is documented by a responsible party.	Ongoing – HR performs employees/travelers/temps monthly. Compliance verifies new referring providers. Medical Staff Office (MSO) verifies all medical staff. Accounting and Compliance verifies all vendors.	Due CY2025 Q2 Annual re-validation for vendor exclusions completed for 2024.
18.	Develop an audit and prepare a report regarding whether all actions relating to the enforcement of disciplinary standards are properly documented.		Due 2025
19.	Audits (Fraud, Waste, and Abuse)		
	a. Arrangements with physician (database)	Physician Contracts are now in a review cycle. All	Due CY2025 Q2

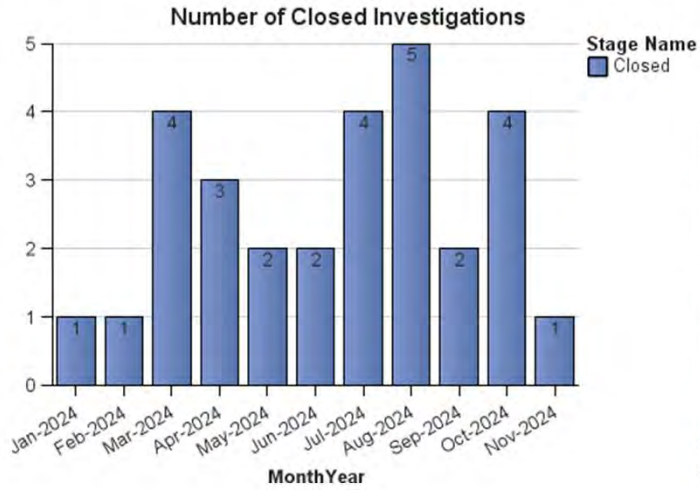
		templates created/reviewed in conjunction with legal counsel (BBK).	
	b. Financial Audits	FY 2025	External audit in progress as of 12/2024
	c. Payment patterns		Due Q2 2025
	d. Bad debt/ credit balances, AR days		Monitored weekly by Revenue Cycle and Business Office. Presented to Board and Compliance monthly.
	e. Non-Physician vendor contract/payment audit		Due CY2025 Q3
	f. DME (Durable Medical Equipment)	HHS OIG target	Chargemaster audit due 2025 Q2
	g. Lab services	MAC target	Deferred
	h. Imaging services (high cost/high usage)	MAC target	Deferred
	i. Rehab services	HHS OIG workplan	Deferred
	j. Language Access Audits	OIG target	Due Q3 2024 – in progress
	k. Cash Box Audits		Random ongoing audits
	l. Imaging Report Compliance Audit	Waiting for corrective action plan	Completed January 2025
	m. Compliance/Accounting – Vendor Conflict of Interest Verification Audit		Due CY2025 Q2
20.	Ensure that high risks associated with HIPAA and HITECH Privacy and Security requirements for protecting health information undergo a compliance review.		Security risk assessment November 2024 with Cybersecurity Officer.
	a. Annual Security Risk Assessment		Due 2025
	b. Periodic update to Security Risk Assessment		As needed
	c. Monthly employee access audits		Daily, ongoing
	d. HIPAA Walkthrough Audits	Implementing ComplyAssistant Software	In progress Jan 2025
	e. BAA Vendor Assessments	Implementing ComplyAssistant Software	In progress Jan 2025
	f. HIPAA Privacy and Security Audit Compliance and Documentation	Implementing ComplyAssistant Software	In progress Jan 2025
21.	Audit required signage		Due 2025
22.	Audit HIMS (Health Information Management) scanned document accuracy		Due 2025

23.	Develop metrics to assess the effectiveness and progress of the Compliance Program	See new guidance from DOJ Evaluation of Corporate Compliance Program (ECCP published 2024)	Due 2025
24.	Review CMS Conditions of Participation		Ongoing
25.	CMS Hospital Price Transparency Audit	MRF, SSPE, PE	Weekly
26.	EMTALA (Emergency Medical Treatment and Active Labor Act)		All EMTALA concerns immediately reviewed. Current through 12/31/2024
Response to Detected Problems and Corrective Action			
27.	Verify that all identified issues related to potential fraud, waste, and abuse are promptly investigated and documented		Current through December 2025
28.	Conduct a review that ensures all identified overpayments are promptly reported and repaid.		Monitored by Revenue Cycle Team and Accounting. Reporting to Compliance as needed.
29.	UOR tracking and trending – UOR/Unusual occurrence reporting is now a function of the Compliance Department.		See UOR reporting attached to Annual Board Report for 2024 attached.
	a. Provide trend feedback to leadership to allow for data-driven decision-making		Quarterly
	I. Overall UOR process		January 2025
	II. Workplace Violence		January 2025
	III. Falls		January 2025
30.	Patient complaints		Documented and tracked in Unusual Occurrence Reporting system
31.	Breach Investigations	HIPAA, HITECH, CMIA	Ongoing. All state and federal reporting requirements were met in 2024.

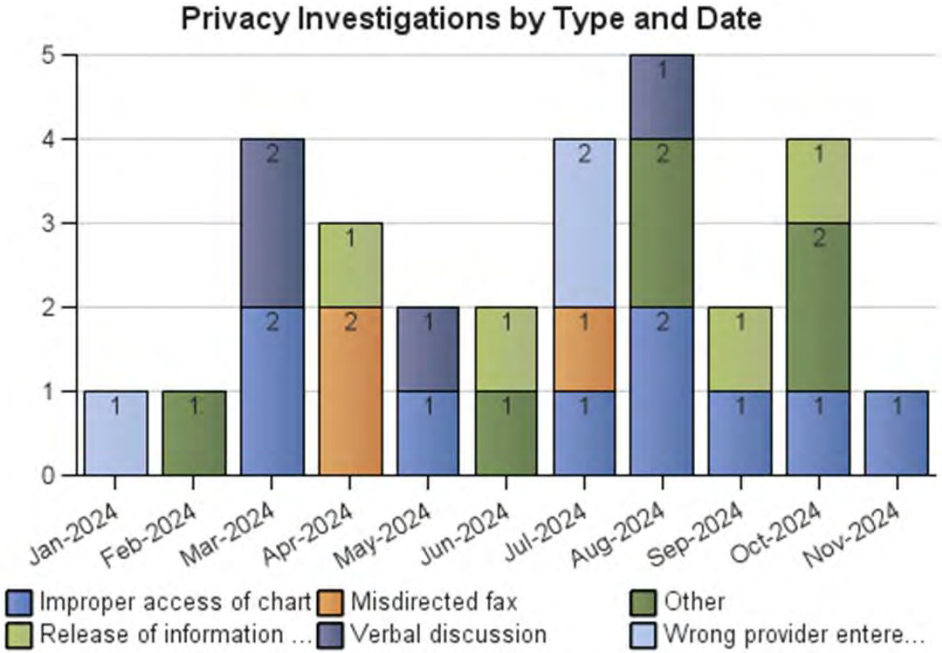




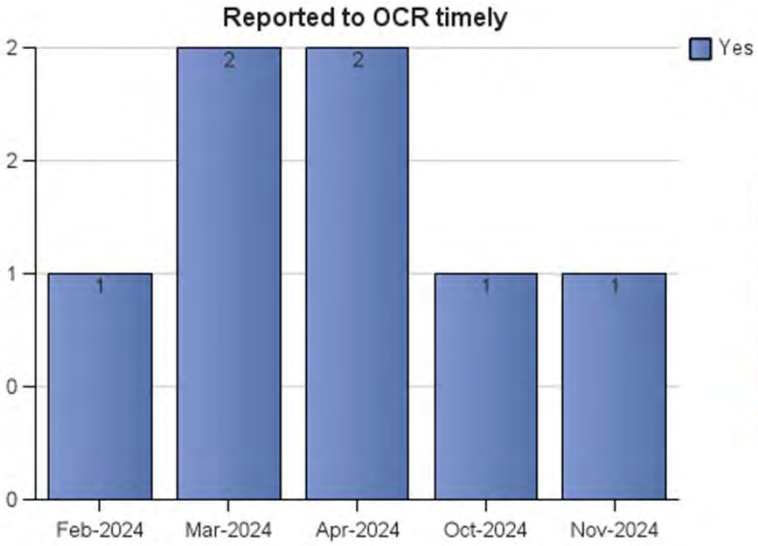
	No	Yes	Total
Jan-2024	1		1
Feb-2024		1	1
Mar-2024	2	2	4
Apr-2024	1	2	3
May-2024	2		2
Jun-2024	2		2
Jul-2024	4		4
Aug-2024	5		5
Sep-2024	2		2
Oct-2024	3	1	4
Nov-2024		1	1
Total	**22**	**7**	**29**



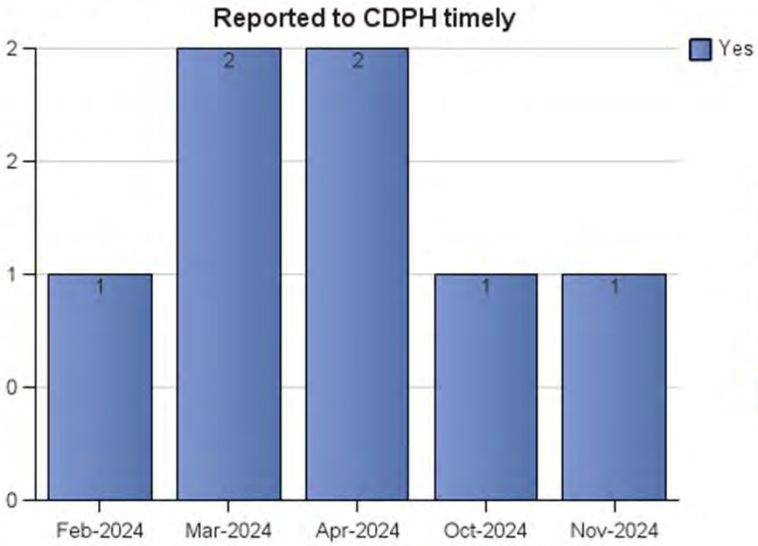
	Closed	Total
Sep-2024	2	2
Oct-2024	4	4
Nov-2024	1	1
May-2024	2	2
Mar-2024	4	4
Jun-2024	2	2
Jul-2024	4	4
Jan-2024	1	1
Feb-2024	1	1
Aug-2024	5	5
Apr-2024	3	3
Total	**29**	**29**



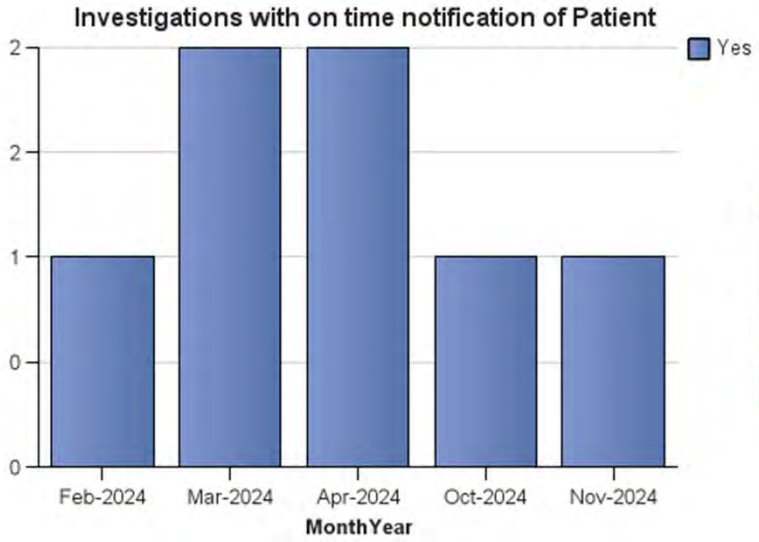
	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Total
Improper access of chart			2		1		1	2	1	1	1	9
Misdirected fax				2			1					3
Other		1				1		2		2		6
Release of information concern				1		1			1	1		4
Verbal discussion			2		1			1				4
Wrong provider entered/selected	1						2					3
Total	**1**	**1**	**4**	**3**	**2**	**2**	**4**	**5**	**2**	**4**	**1**	**29**



	Yes	Total
Feb-2024	1	1
Mar-2024	2	2
Apr-2024	2	2
Oct-2024	1	1
Nov-2024	1	1
Total	7	7



	Yes	Total
Feb-2024	1	1
Mar-2024	2	2
Apr-2024	2	2
Oct-2024	1	1
Nov-2024	1	1
Total	7	7



	Yes	Total
Feb-2024	1	1
Mar-2024	2	2
Apr-2024	2	2
Oct-2024	1	1
Nov-2024	1	1
Total	7	7

DEPARTMENT OF HEALTH & HUMAN SERVICES
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OFFICE OF THE SECRETARY
Office for Civil Rights, Pacific Region
90 7th Street, Suite 4-100
San Francisco, California 94103

December 30, 2024

Patty Dickson
Compliance and Privacy Officer
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514
Sent via email: **patty.dickson@nih.org**

Leeann Habte
Partner
Best, Best, & Krieger LLP
Sent via email: **leeann.habte@bbklaw.com**

OCR Reference Number: 24-558331

Dear Ms. Dickson and Ms. Habte:

The U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR) received a breach notification report on January 3, 2024, from Northern Inyo Healthcare District, pursuant to the HITECH Breach Notification Rules, 45 C.F.R. §§ 164.408 and 164.414, respectively. The Breach Report indicated to OCR that Northern Inyo Healthcare District (the Covered Entity), may not be in compliance with the Federal Standards for Privacy of Individually Identifiable Health Information and/or the Security Standards for the Protection of Electronic Protected Health information and/or the Notification in the Case of Breach of Unsecured Protected Health Information (45 C.F.R. Parts 160 and 164, Subparts A, C, D, and E, the Privacy, Security, and Breach Notification Rules).

Specifically, the breach notification report indicated that Keenan & Associates (Keenan) is a business associate of Northern Inyo Healthcare District who adjudicates claims for Northern Inyo Healthcare District's self-pay insurance plan. On Sunday, August 27, Keenan discovered certain disruptions occurring on some Keenan network servers. Keenan immediately began investigating the issue and discovered suspicious activity on a limited number of servers. As a precaution, Keenan disconnected the entire network to contain the incident. Keenan has engaged leading third-party cybersecurity and forensic experts to assist in the investigation and remediation, and law enforcement has been notified. Within hours of identifying the incident, Keenan had contained it.

Keenan's investigation determined that an unauthorized party gained access to certain Keenan internal systems at various times between approximately August 21, 2023, and August 27, 2023. Findings from the investigation indicate that the unauthorized party obtained some data from certain Keenan systems during this period. Keenan was able to retrieve the data involved from the unauthorized party and has taken steps to delete the data. At this time, Keenan has no reason to believe this data was further copied or retained by the unauthorized party.

Keenan conducted a thorough review of the data involved in order to identify individuals whose personal information was included. On or around December 11, 2023, Keenan completed its review of the data and began notifying covered entity clients of any client-related personal information included in these files. The review determined that the files contained personal health information along with other personal information for a subset of its clients.

Keenan is not aware of any fraud or misuse of any personal information as a result of this incident. Keenan does not believe personal information was targeted by the unauthorized party for identify theft purposes, but rather, such information happened to be included in documents taken by the unauthorized party as part of the ransomware incident to extort the company.

To help prevent a similar type of incident from occurring in the future, Keenan implemented additional security protocols designed to enhance the security of its network, internal systems, and applications. Keenan also continues to evaluate additional steps that may be taken to further increase its defenses going forward.

OCR investigated this Breach Report under the following potential violations: 45 C.F.R. §§ 164.308(a)(1)(ii)(A) - Risk Analysis, 164.308(a)(1)(ii)(B) - Risk Management, 164.308(a)(1)(ii)(D) – Information System Activity Review, 164.308(a)(5)(i) – Security Awareness and Training, 45 C.F.R. 164.308(a)(5)(ii)(B) – Protection from Malicious Software, 164.308(a)(5)(ii)(B), 164.308(a)(6)(i) – Security Incident Procedures, 164.308(a)(6)(ii) - Response and Reporting, 164.308(a)(7)(ii)(A) – Data Backup Plan, 164.312(a)(1) – Access Control, 164.312(a)(2)(iv) – Encryption and Decryption, 164.312(b) – Audit Controls, 164.312(c)(1) – Integrity Standard, 164.314(a)(1) – Business associate contracts or other arrangements, 164.404(a) - Notice to Individuals, 164.406(a) - Notice to the Media, 164.502(a) - Uses and disclosures, 164.530(c) – Safeguards, and 164.530(f) - Mitigation.

OCR enforces the Privacy, Security, and Breach Notification Rules and also enforces Federal civil rights laws that prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and, under certain circumstances, sex, and religion and the exercise of conscience.

Summary of Investigation

On March 18, 2024, OCR notified the Covered Entity, of the investigation. On May 1, 2024, OCR received the Covered Entity's responses to the investigatory questions. A summary of the Covered Entity's responses, applicable to this investigation, is provided below:

The Covered Entity is a local governmental entity that operates a self-insured health plan for medical insurance provided as an employee benefit to its employees. The Covered Entity employes 433 individuals and is covered under HIPAA as a health plan.

The Covered Entity operates Northern Inyo Hospital, a general acute care hospital, where a majority of its employees work. This hospital is designated as a Critical Access Hospital by the Center for Medicare and Medicaid Services. As a small Critical Access Hospital, Northern Inyo Hospital is

only licensed for 25 beds and has an average daily census of 4.8. It serves Bishop, California and its rural surrounding areas.

Keenan adjudicates health care claims data as a third-party administrator for the Covered Entity's employee health insurance plan. Keenan receives protected health information (PHI) from Covered Entity employees in their health care claims. Therefore, Keenan is a business associate of the Covered Entity as defined at 45 C.F.R. § 160.103.

On December 11, 2023, Keenan, via its legal counsel, informed the Covered Entity of a cybersecurity ransomware incident that occurred on Keenan's databases between August 21, 2023, and August 27, 2023. The incident was reported pursuant to the Covered Entity's Business Associate Agreement (BAA) with Keenan.

On August 27, 2023, Keenan discovered disruption on some of its network servers. Once it began investigating the issue, Keenan discovered suspicious activity on a limited number of servers and disconnected its network to contain the suspicious activity. Keenan then reportedly engaged third-party cybersecurity experts to assist in investigating and responding to the incident. Additionally, Keenan notified law enforcement of the incident.

Upon investigation, Keenan determined that an unauthorized party gained access to certain Keenan internal systems at various times between August 21, 2023, and August 27, 2023. During this period, the unauthorized party stole files from a limited number of Keenan file shares. The unauthorized party also deployed ransomware, which encrypted data on some Keenan systems.

On January 18, 2024, Covered Entity's counsel requested additional information from Keenan regarding the breach incident. The letter requested specific information about Keenan's reports to law enforcement, a copy of the four-factor risk assessment Keenan conducted, a copy or summary of the forensic report Keenan conducted, and an explanation of what actions Keenan has taken to mitigate harm and to remediate any security vulnerabilities identified.

On February 16, 2024, Keenan responded to the Covered Entity's request stating it notified the FBI after discovering the incident and that it was continuing to support the FBI's investigation. Keenan also noted it first reported the incident to the FBI on or about August 30, 2023. Keenan did not provide a copy of its report or notification to the FBI of the incident. However, Keenan did provide the Covered Entity with its four-factor risk assessment as well as its confidential forensic report from its third-party forensics' vendor. Keenan also provided the Covered Entity what it believed to be the root cause of the incident as well as the steps taken to remediate the vulnerabilities identified. Among those listed were replaced on-premises network server where the vulnerability was exploited and purchased and implemented additional security tools.

In response to the incident and Keenan's responses, the Covered Entity completed the following corrective and/or mitigating actions:

1. The Covered Entity notified affected individuals, explaining the security incident, what information was involved, steps taken to mitigate, as well as steps individuals may consider taking in response to this incident. Specifically, the Covered Entity informed the

affected individuals of a complimentary 24-month membership in Experian IdentityWorksSM Credit 3B offered by Keenan.

2. Requested a Corrective Action Plan from Keenan associated with its lack of timely notification of the suspected breach and security incident that resulted in unauthorized access to PHI.

3. Provided OCR with copies of correspondence between Keenan and the Covered Entity as it relates to the corrective actions taken by Keenan in response to the breach incident.

Technical Assistance

OCR is providing technical assistance regarding the HIPAA/HITECH Privacy and Security Rules:

Covered Entities or Business Associates, such as Northern Inyo Healthcare District, are required to complete regular risk analyses and corresponding risk management. Specifically, the Security Management Process standard, at 45 C.F.R. § 164.308(a)(1)(i) in the Administrative Safeguards section of the Security Rule, requires organizations to implement policies and procedures to prevent, detect, contain, and correct security violations. The Security Management Process standard has four required implementation specifications. Two of the implementation specifications are Risk Analysis and Risk Management. The required implementation specification for Risk Analysis, at 45 C.F.R. § 164.308(a)(1)(ii)(A), requires organizations to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of ePHI held by the organization, including all ePHI created, received, maintained, or transmitted. The required implementation specification for Risk Management, at 45 C.F.R. § 164.308(a)(1)(ii)(B), requires organizations to implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level. Risk Management is an integral part of the security management process; including identification of key staff responsible for completing mitigation and projected completion dates. Both Risk Analysis and Risk Management are standard information security processes and are critical to an organization's Security Rule compliance efforts.

You are encouraged to visit OCR's website, where you will find educational materials to help you learn more about the HIPAA/HITECH Privacy, Security, and Breach Notification Rules:

https://www.hhs.gov/hipaa/for-professionals/index.html;
https://www.hhs.gov/hipaa/for-professionals/breach-notification/index.html; and
http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/securityruleguidance.html.

OCR reviewed the documentation provided by the Covered Entity, including its policies and procedures as they relate to the HIPAA Privacy, Security, and Breach Notification Rules.

Based on the foregoing, OCR is closing this case without further action, effective the date of this letter. OCR's determination as stated in this letter applies only to the allegations in this complaint that were reviewed by OCR.

If you have any questions regarding this matter, please contact Steven Soto, the OCR investigator assigned to this case, at (213) 310-4684 (Voice) or by e-mail at Steven.Soto@hhs.gov.

Sincerely,

Michael Leoz
Regional Manager

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mailstop: C5-15-12
Baltimore, Maryland 21244-1850

Center for Medicare

November 8, 2024

Stephen DelRossi
CEO
Northern Inyo Hospital
150 Pioneer Lane
Bishop, CA 93514-2599

Reference Number: 45082024

RE: Hospital Price Transparency – Closure Notice

Dear Stephen DelRossi,

The Centers for Medicare & Medicaid Services (CMS) completed a review of Northern Inyo Hospital's website http://www.nih.org on November 8, 2024 and determined that the deficiencies identified in the Notice of Violation and Request for Corrective Action Plan (CAP) issued August 7, 2024 have been rectified.

Please consider this a **notification that this ends our compliance review referenced in the August 7, 2024 Notice of Violation and Request for Corrective Action Plan (CAP).**

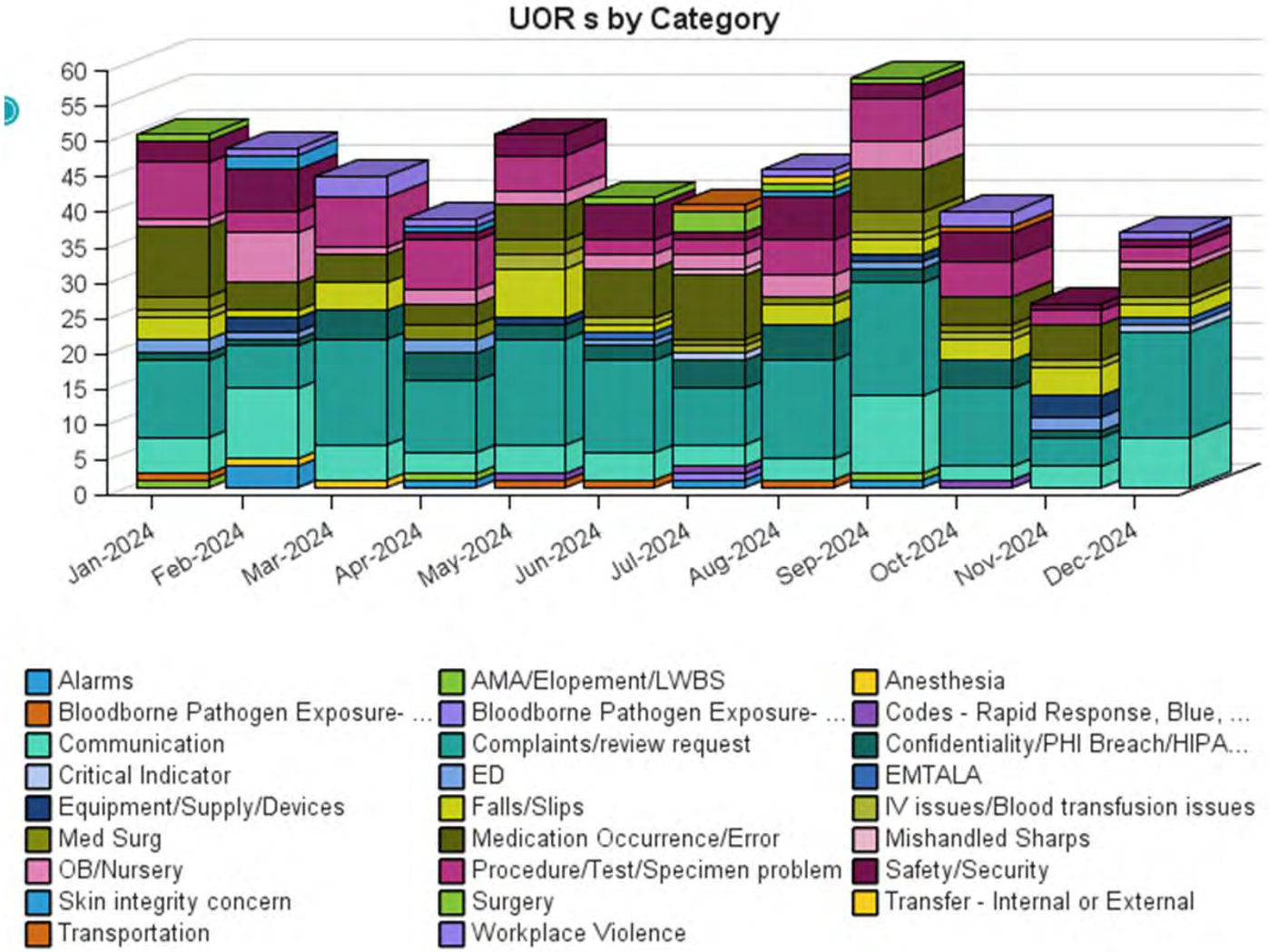
CMS may continue to evaluate your hospital's compliance. It is incumbent upon Northern Inyo Hospital to remain in full compliance with all CMS Hospital Price Transparency requirements at 45 C.F.R. Part 180, including compliance with new regulations that may become effective or implemented after the date of this notice.

If you have questions, please contact us at HPTCompliance@cms.hhs.gov.

Calendar Year 2024
Unusual Occurrence Report (UOR) Data

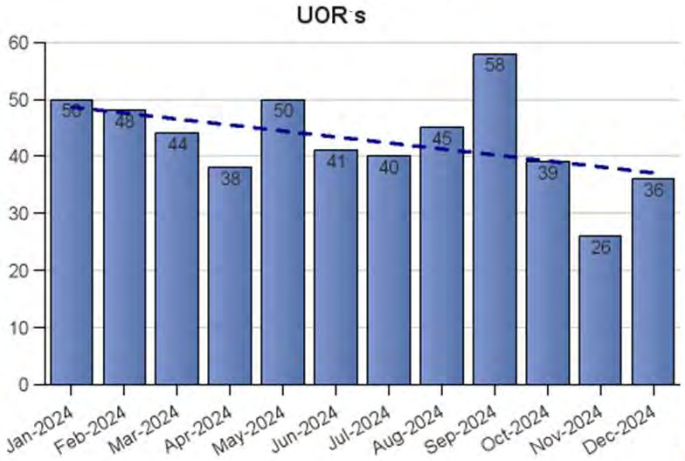
Some of the 2024 systemic changes resulting from UORs:

- Laser labeling of pathology slides.
- Medication protocol, supplies, and infusion pump programming process es streamlined for easier access in emergencies.
- Additional staffing added to clinic to ensure all voicemails are reviewed daily.
- Adjusted thresholds in Pioneer Medical Building to allow for easier/safer access to Rehab areas.
- Updated form processes and monitoring of EDD (Employment Development Department – unemployment insurance, disability insurance, paid family leave) to improve services to affected patients.
- Implemented an improved process to verify drug pricing, as it fluctuates frequently to ensure correct drug pricing.
- Pre-op workflow improved to ensure pre-op tests are not missed, all documentation verified.
- Relocated the Authorization and Referral Department to a clinical area to assist with providing correct documentation, review and streamline the authorization process to provide improved and faster service for authorization.
- Posted Service Animal signs around District entrances to inform the public of District policy and California/Federal laws regarding service animals vs. support animals.
- Building or re-building order sets in the electronic health record to ensure streamlined orders during emergencies in multiple medical and surgical areas.

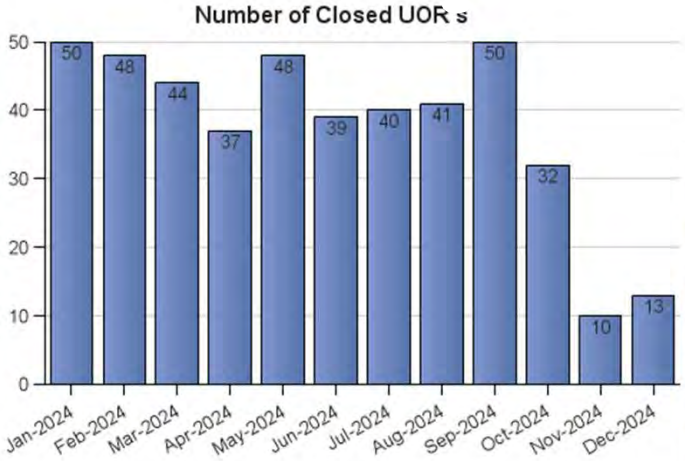

UOR s by Category
60
55
50
45
40
35
30
25
20
15
10
5
0
Jan-2024
Feb-2024
Mar-2024
Apr-2024
May-2024
Jun-2024
Jul-2024
Aug-2024
Sep-2024
Oct-2024
Nov-2024
Dec-2024
Alarms
AMA/Elopement/LWBS
Anesthesia
Bloodborne Pathogen Exposure- ...
Bloodborne Pathogen Exposure- ...
Codes - Rapid Response, Blue, ...
Communication
Complaints/review request
Confidentiality/PHI Breach/HIPA...
Critical Indicator
ED
EMTALA
Equipment/Supply/Devices
Falls/Slips
IV issues/Blood transfusion issues
Med Surg
Medication Occurrence/Error
Mishandled Sharps
OB/Nursery
Procedure/Test/Specimen problem
Safety/Security
Skin integrity concern
Surgery
Transfer - Internal or External
Transportation
Workplace Violence

Data for previous slide

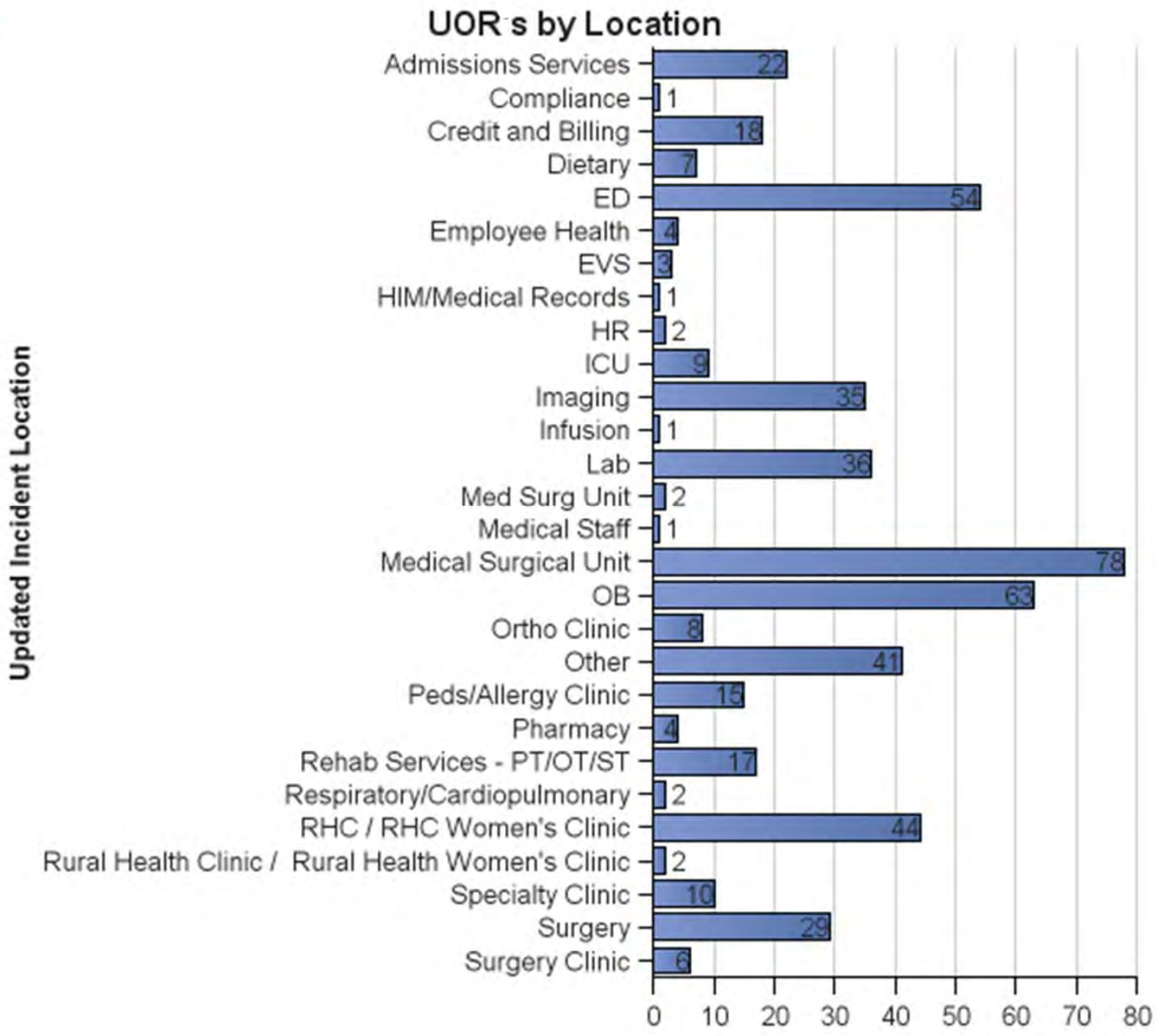
	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Total
Alarms		3		1			1		1				6
AMA/Elopement/LWBS	1			1					1				3
Anesthesia		1	1										2
Bloodborne Pathogen Exposure- Sharps Injury	1				1	1		1					4
Bloodborne Pathogen Exposure- Splash/ Mucous Membrane							1						1
Codes - Rapid Response, Blue, Deescalation					1		1			1			3
Communication	5	10	5	3	4	4	3	3	11	2	3	7	60
Complaints/review request	11	6	15	10	15	13	8	14	16	11	4	15	138
Confidentiality/PHI Breach/HIPAA violation	1	1	4	4	2	2	4	5	2	4	1		30
Critical Indicator							1					1	2
ED	2	1		2		1			1		2		9
EMTALA						1						1	2
Equipment/Supply/Devices		2			1				1		3		7
Falls/Slips	3	1	4		7	1		3	2	3	4	2	30
IV issues/Blood transfusion issues	1				2	1	1		1	1	1	1	9
Med Surg	2			2	2		1	1	3	1			12
Medication Occurrence/Error	10	4	4	3	5	7	9		6	4	5	4	61
Mishandled Sharps							1						1
OB/Nursery	1	7	1	2	2	2	2	3	4			1	25
Procedure/Test/Specimen problem	8	3	7	7	5	2	2	5	6	5	2	2	54
Safety/Security	3	6		1	3	5	1	6	2	4	1	1	33
Skin integrity concern		2		1				1					4
Surgery	1					1	3	1	1				7
Transfer - Internal or External								1					1
Transportation							1			1			2
Workplace Violence		1	3	1				1		2		1	9
Total	**50**	**48**	**44**	**38**	**50**	**41**	**40**	**45**	**58**	**39**	**26**	**36**	**515**



Jan-2024	50
Feb-2024	48
Mar-2024	44
Apr-2024	38
May-2024	50
Jun-2024	41
Jul-2024	40
Aug-2024	45
Sep-2024	58
Oct-2024	39
Nov-2024	26
Dec-2024	36
Total	**515**



	Closed
Jan-2024	50
Feb-2024	48
Mar-2024	44
Apr-2024	37
May-2024	48
Jun-2024	39
Jul-2024	40
Aug-2024	41
Sep-2024	50
Oct-2024	32
Nov-2024	10
Dec-2024	13
Total	**452**

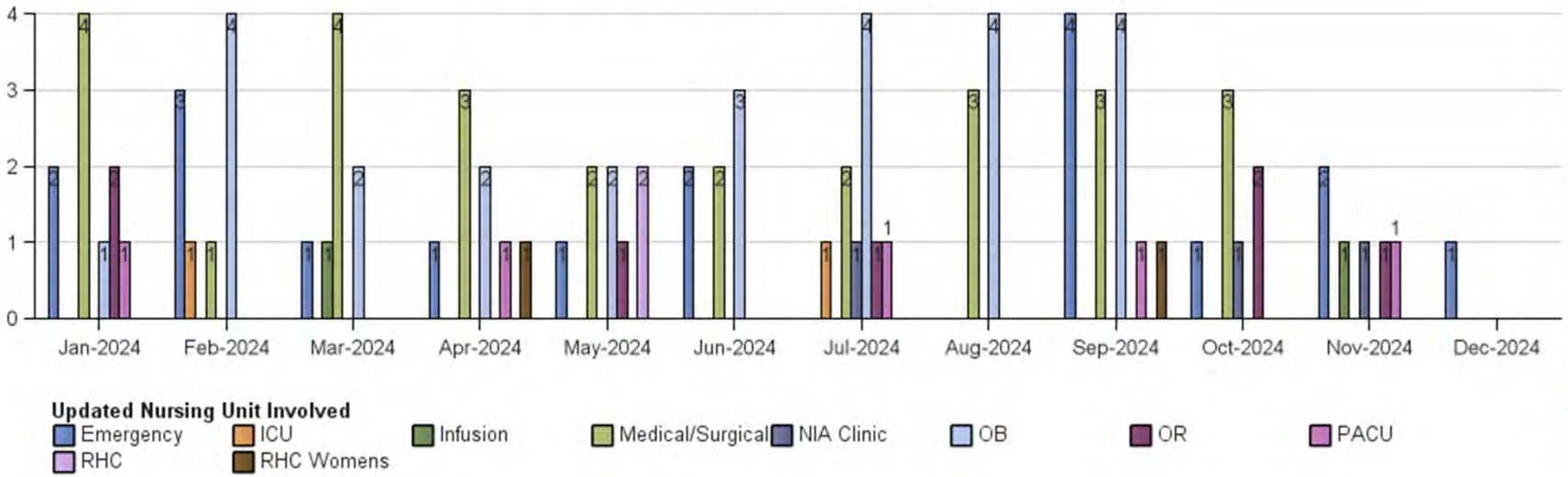

UOR s by Location
Updated Incident Location
Admissions Services
Compliance
Credit and Billing
Dietary
ED
Employee Health
EVS
HIM/Medical Records
HR
ICU
Imaging
Infusion
Lab
Med Surg Unit
Medical Staff
Medical Surgical Unit
OB
Ortho Clinic
Other
Peds/Allergy Clinic
Pharmacy
Rehab Services - PT/OT/ST
Respiratory/Cardiopulmonary
RHC / RHC Women's Clinic
Rural Health Clinic / Rural Health Women's Clinic
Specialty Clinic
Surgery
Surgery Clinic
22
1
18
7
54
4
3
1
2
9
35
1
36
2
1
78
63
8
41
15
4
17
2
44
2
10
29
6
0
10
20
30
40
50
60
70
80

Data for previous slide

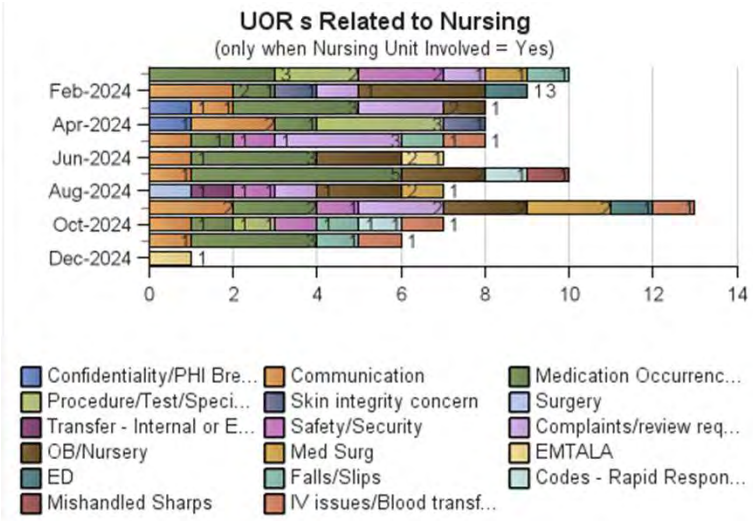
Admissions Services	22
Compliance	1
Credit and Billing	18
Dietary	7
ED	54
Employee Health	4
EVS	3
HIM/Medical Records	1
HR	2
ICU	9
Imaging	35
Infusion	1
Lab	36
Med Surg Unit	2
Medical Staff	1
Medical Surgical Unit	78
OB	63
Ortho Clinic	8
Other	41
Peds/Allergy Clinic	15
Pharmacy	4
Rehab Services - PT/OT/ST	17
Respiratory/Cardiopulmonary	2
RHC / RHC Women's Clinic	44
Rural Health Clinic / Rural Health Wor	2
Specialty Clinic	10
Surgery	29
Surgery Clinic	6
Total	**515**

UOR s Related to Nursing by Nursing Unit Involved

(only when Nursing Unit Involved = Yes)

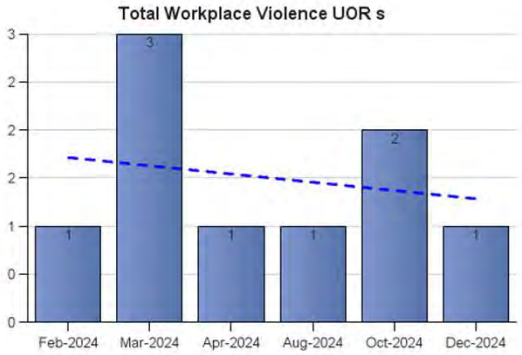


	Yes
Emergency	18
ICU	2
Infusion	2
Medical/Surgical	27
NIA Clinic	3
OB	26
OR	7
PACU	5
RHC	2
RHC Womens	2
Total	**94**

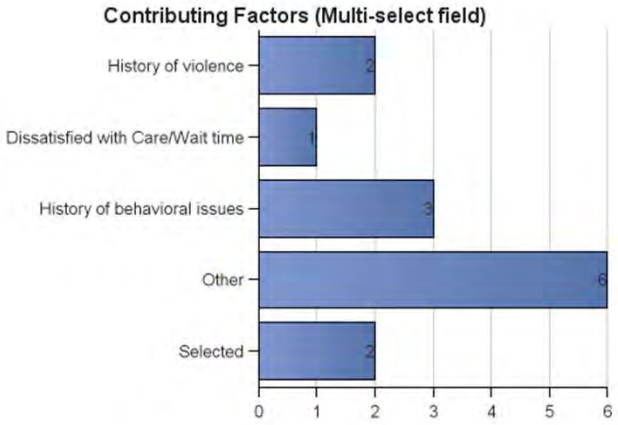


	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Total
Confidentiality/PHI Breach/HIPAA violation			1	1									2
Communication		2	1	2	1	1	1		2	1	1		12
Medication Occurrence/Error	3	1	3	1	1	3	5		2	1	3		23
Procedure/Test/Specimen problem	2			3						1			6
Skin integrity concern		1		1									2
Surgery								1					1
Transfer - Internal or External								1					1
Safety/Security	2				1			1	1	1			6
Complaints/review request	1	1	2		3			1	2				10
OB/Nursery		3	1			2	2	2	2				12
Med Surg	1							1	2				4
EMTALA						1						1	2
ED		1							1				2
Falls/Slips	1				1					1	1		4
Codes - Rapid Response, Blue, Deescalation							1			1			2
Mishandled Sharps							1						1
IV issues/Blood transfusion issues					1				1	1	1		4
Total	**10**	**9**	**8**	**8**	**8**	**7**	**10**	**7**	**13**	**7**	**6**	**1**	**94**

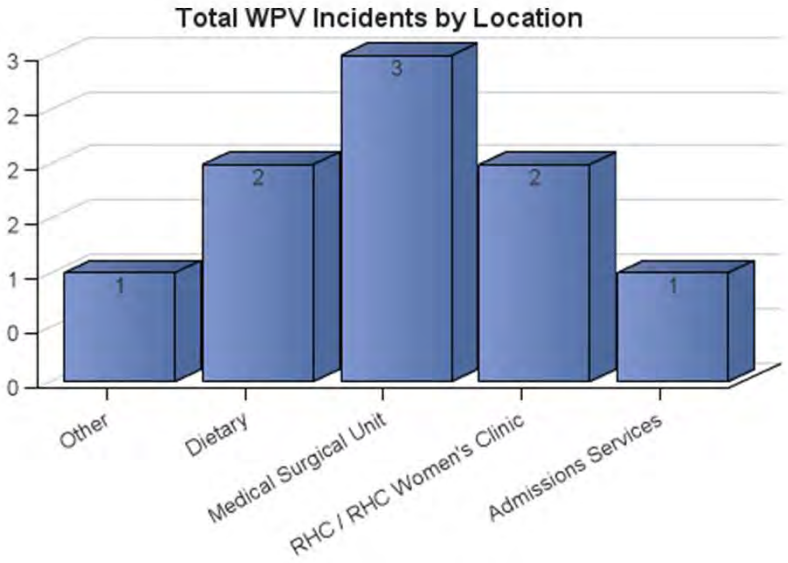
WORKPLACE VIOLENCE



	Feb-2024	Mar-2024	Apr-2024	Aug-2024	Oct-2024	Dec-2024	Total
Workplace Violence	1	3	1	1	2	1	9
Total	**1**	**3**	**1**	**1**	**2**	**1**	**9**

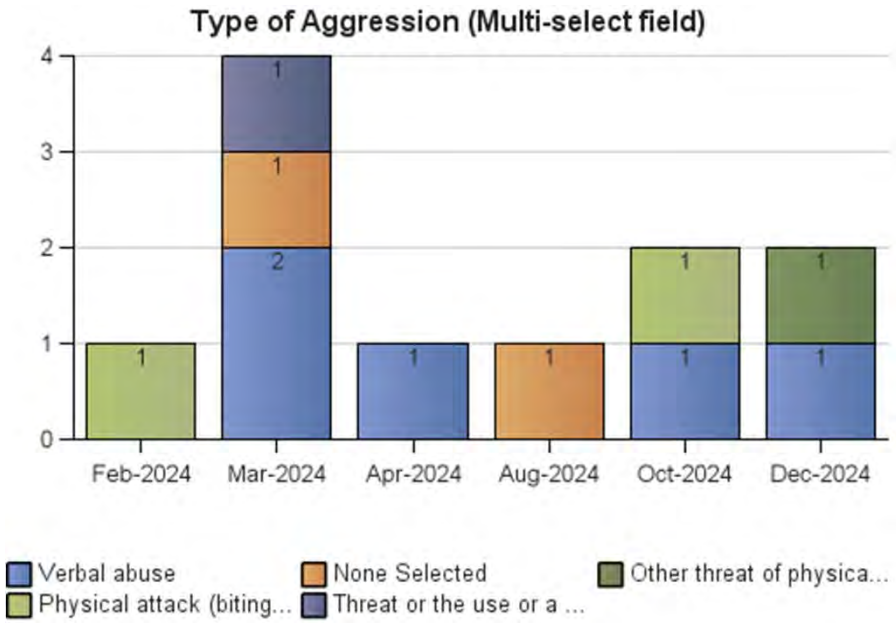


None Selected	2
Dissatisfied with Care/Wait time	1
History of behavioral issues	3
History of violence	2
Other	4
Total	**12**



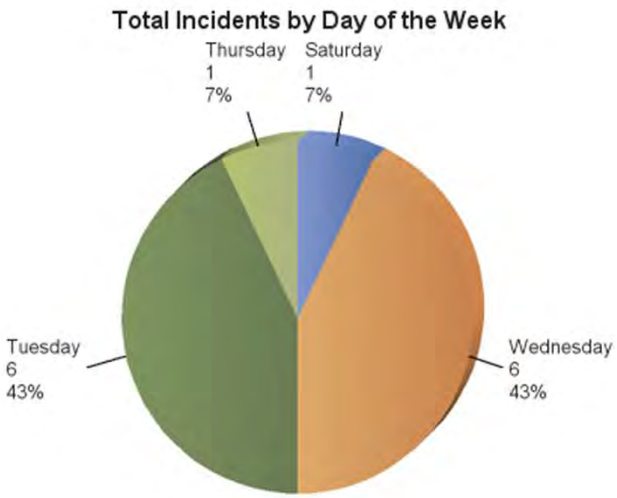
Other	1
Dietary	2
Medical Surgical Unit	3
RHC / RHC Women's Clinic	2
Admissions Services	1
Total	**9**

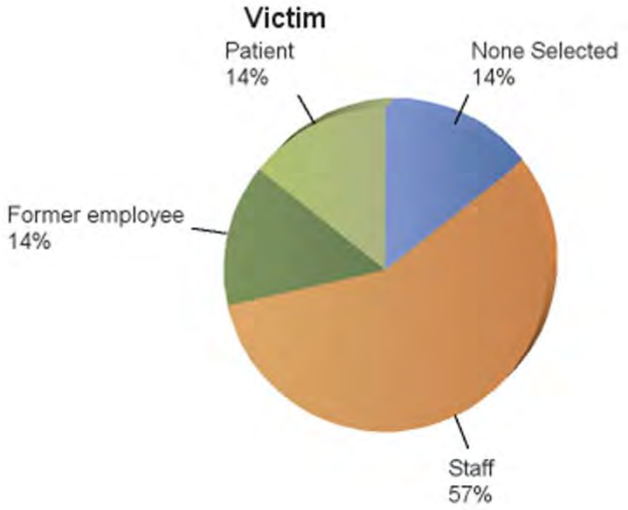
WORKPLACE VIOLENCE

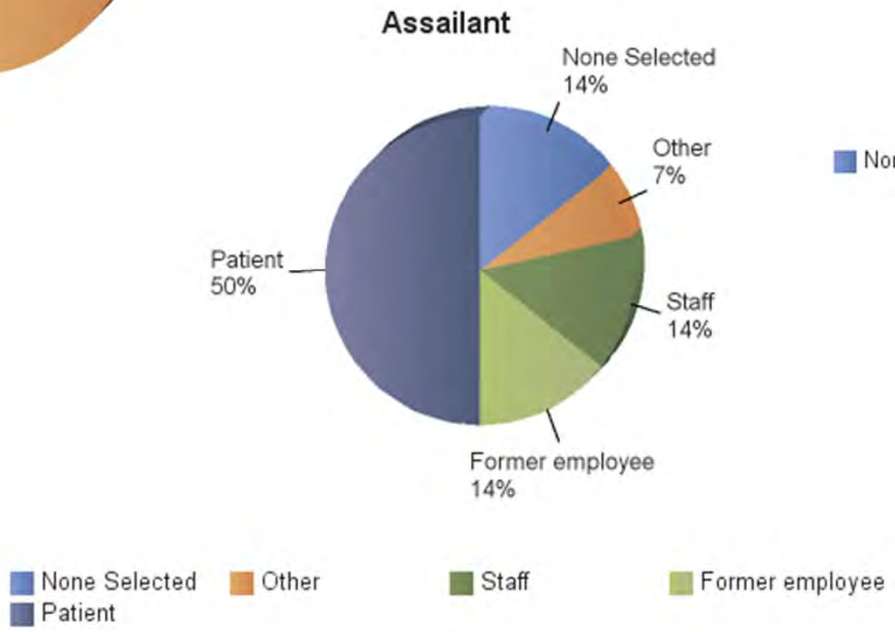


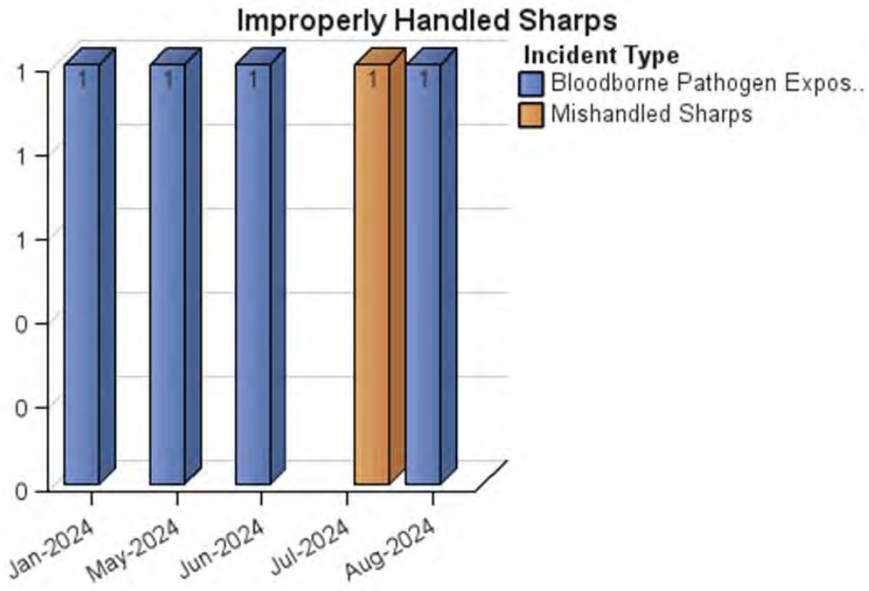
	Feb-2024	Mar-2024	Apr-2024	Aug-2024	Oct-2024	Dec-2024	Total
Verbal abuse		2	1		1	1	5
None Selected		1		1			2
Other threat of physical force						1	1
Physical attack (biting, choking, grabbing, hair pulling, kicking, punching/slapping, scratching, spitting, striking, etc)	1				1		2
Threat or the use or a weapon/object		1					1
Total	**1**	**4**	**1**	**1**	**2**	**2**	**11**

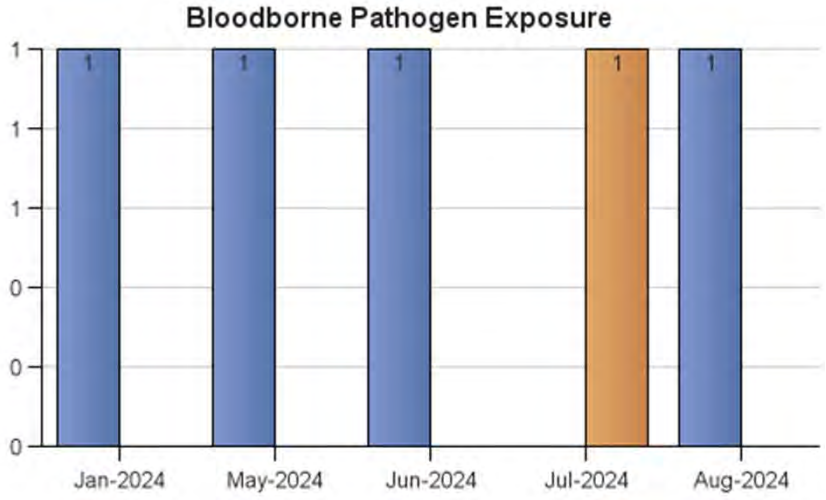
WORKPLACE VIOLENCE





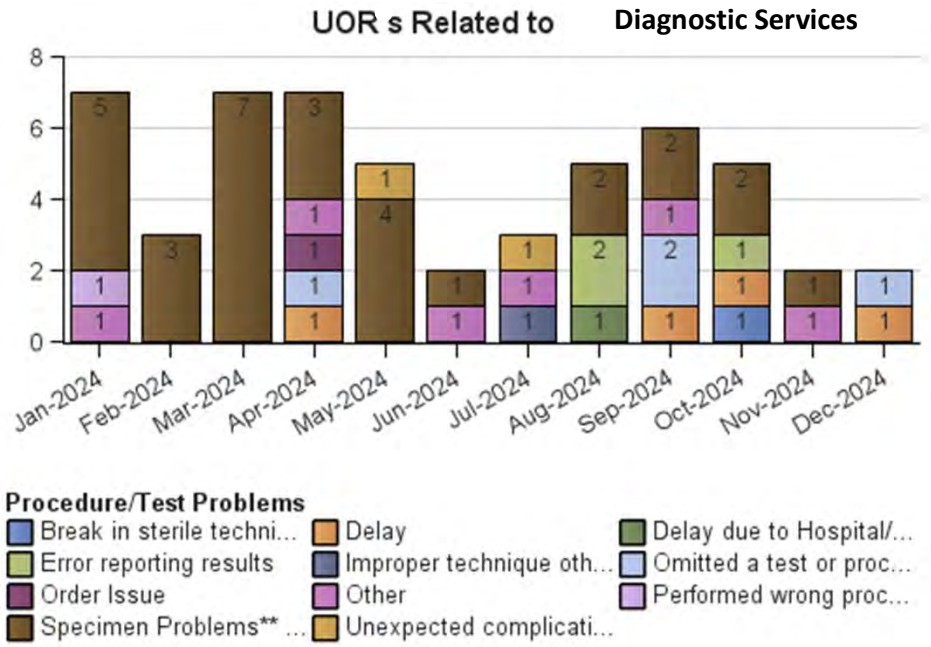






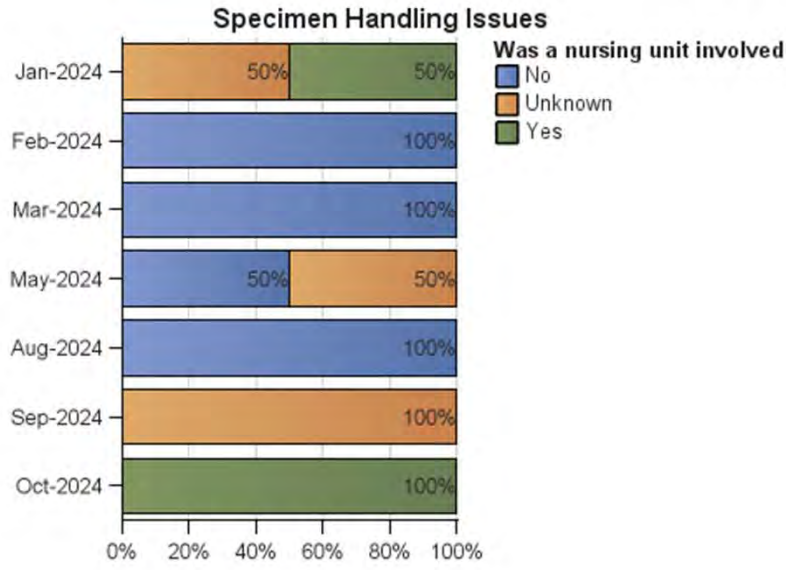
	Jan-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Total
Bloodborne Pathogen Exposure- Sharps Injury	1	1	1		1	4
Mishandled Sharps				1		1
Total	**1**	**1**	**1**	**1**	**1**	5

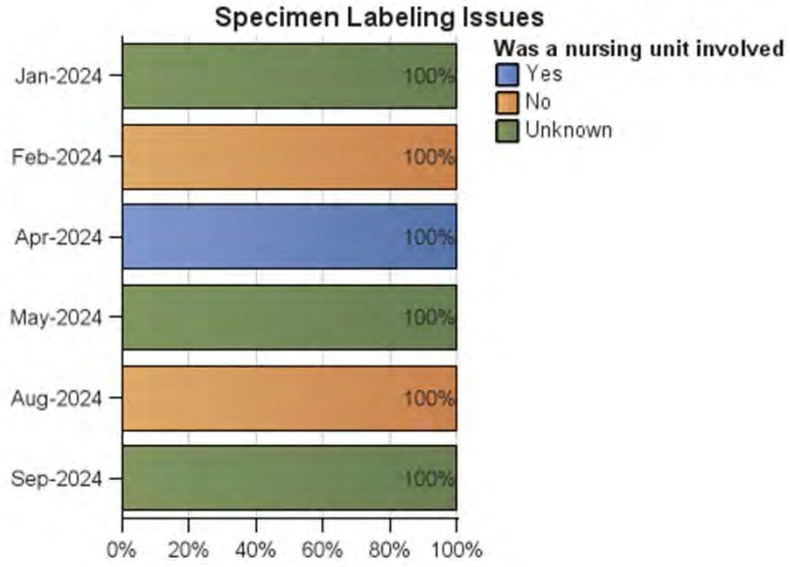
	Jan-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Total
Bloodborne Pathogen Exposure- Sharps Injury	1	1	1		1	4
Bloodborne Pathogen Exposure- Splash/ Mucous Membrane				1		1
Total	**1**	**1**	**1**	**1**	**1**	5



	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Total
Break in sterile technique										1			1
Delay				1					1	1		1	4
Delay due to Hospital/Radiology systems problems or communication issues								1					1
Error reporting results								2		1			3
Improper technique other than a break in sterile technique							1						1
Omitted a test or procedure				1					2			1	4
Order Issue				1									1
Other	1			1		1	1		1		1		6
Performed wrong procedure	1												1
Specimen Problems** LAB ALWAYS SELECT THIS ONE***	5	3	7	3	4	1		2	2	2	1		30
Unexpected complications					1		1						2
Total	**7**	**3**	**7**	**7**	**5**	**2**	**3**	**5**	**6**	**5**	**2**	**2**	**54**

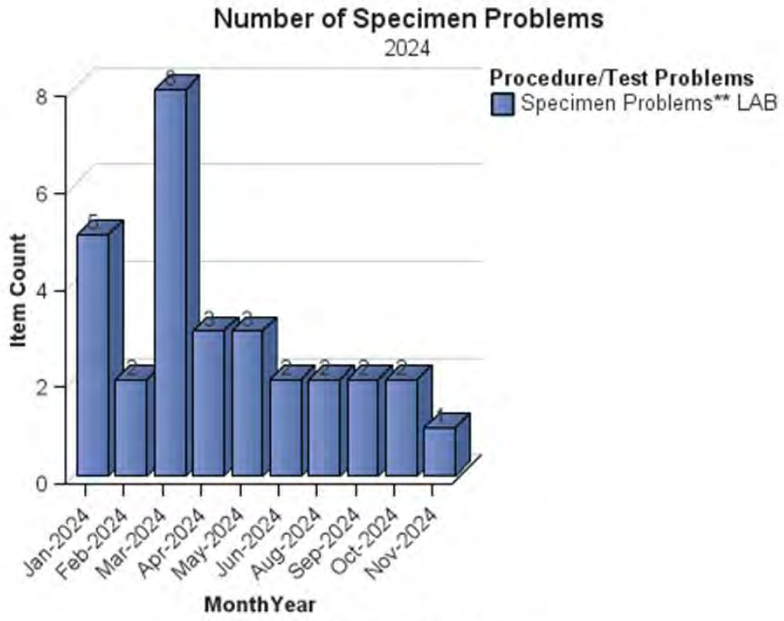
See new reports in the following pages

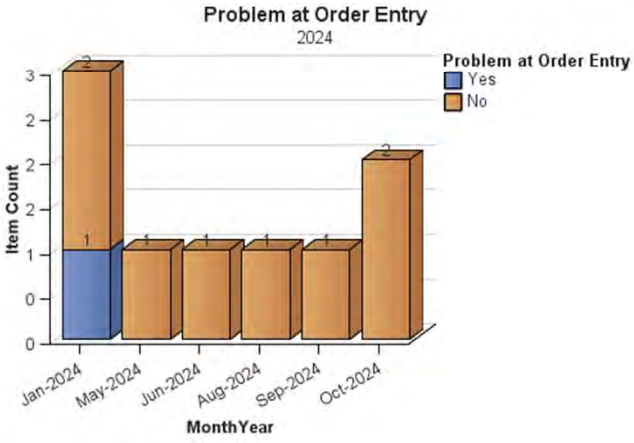


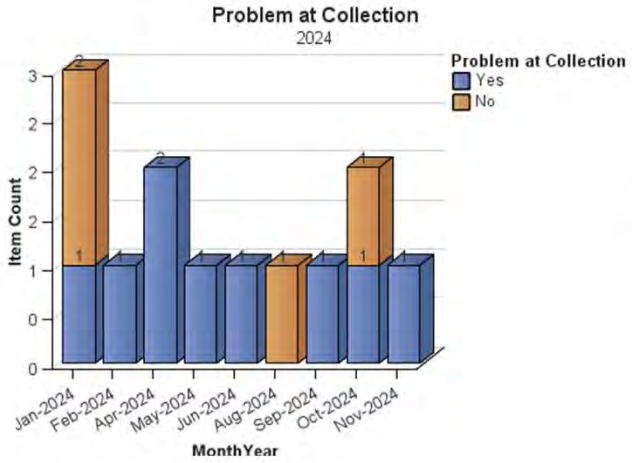


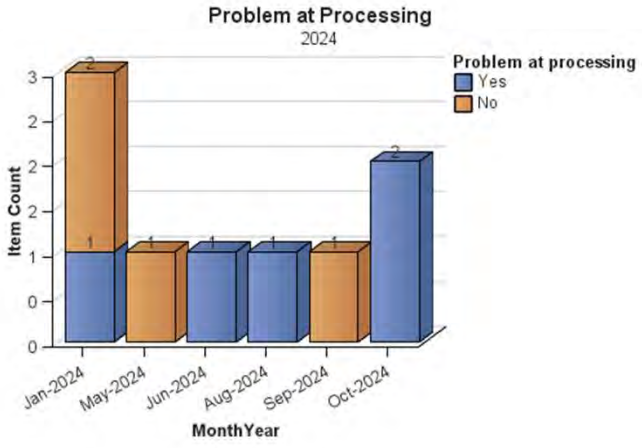
	Jan-2024	Feb-2024	Mar-2024	May-2024	Aug-2024	Sep-2024	Oct-2024	Total
No		1	7	1	1			10
Unknown	1			1		1		3
Yes	1						1	2
Total	**2**	**1**	**7**	**2**	**1**	**1**	**1**	**15**

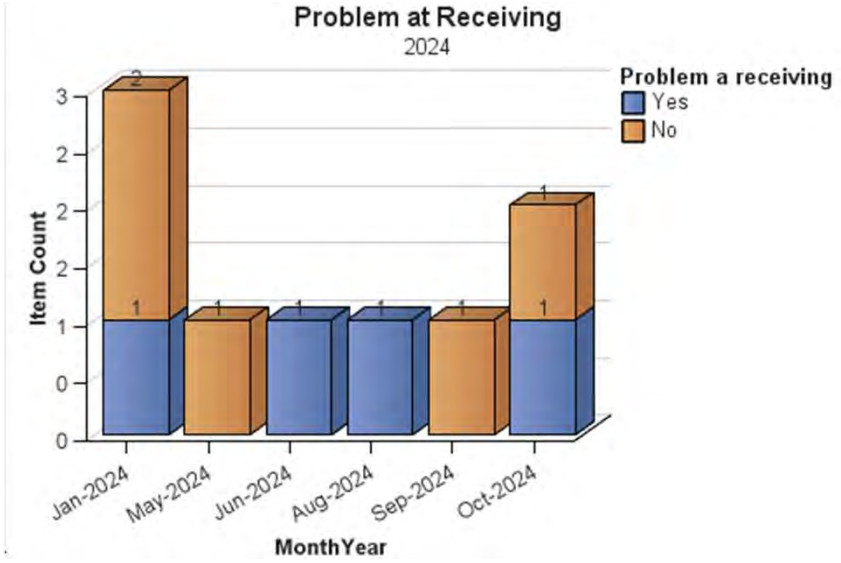
	Jan-2024	Feb-2024	Apr-2024	May-2024	Aug-2024	Sep-2024	Total
Yes			2				2
No		1			1		2
Unknown	1			2		1	4
Total	**1**	**1**	**2**	**2**	**1**	**1**	**8**

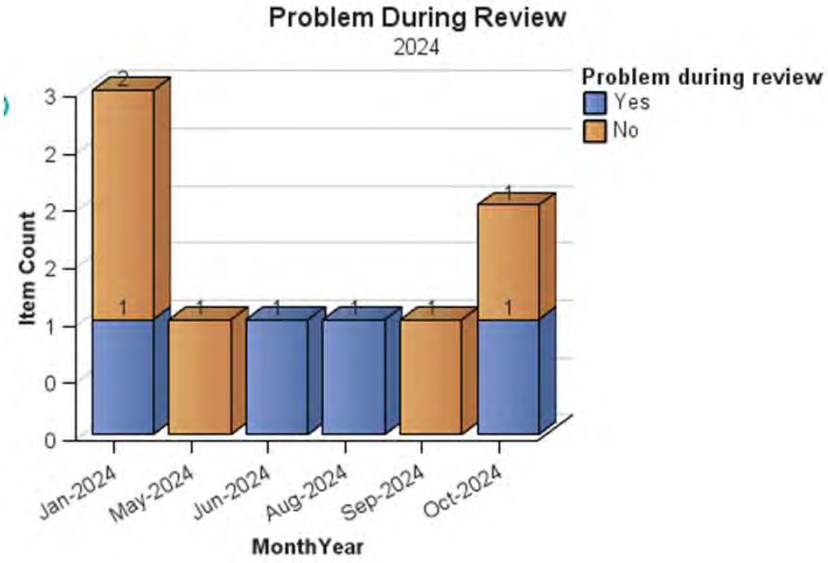

Number of Specimen Problems
2024
Procedure/Test Problems
Specimen Problems** LAB
Item Count
MonthYear
Jan-2024
Feb-2024
Mar-2024
Apr-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024
Nov-2024

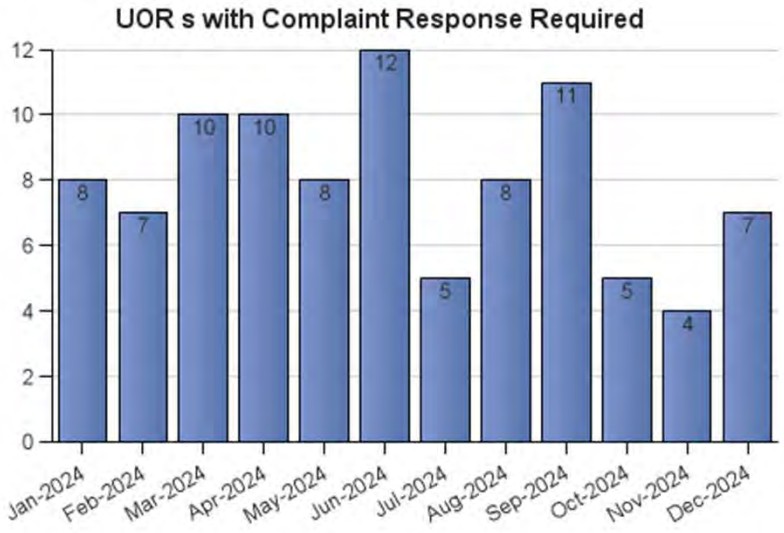

Problem at Order Entry
2024
Problem at Order Entry
Yes
No
Item Count
MonthYear
Jan-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024


Problem at Collection
2024
Problem at Collection
Yes
No
Item Count
MonthYear
Jan-2024
Feb-2024
Apr-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024
Nov-2024

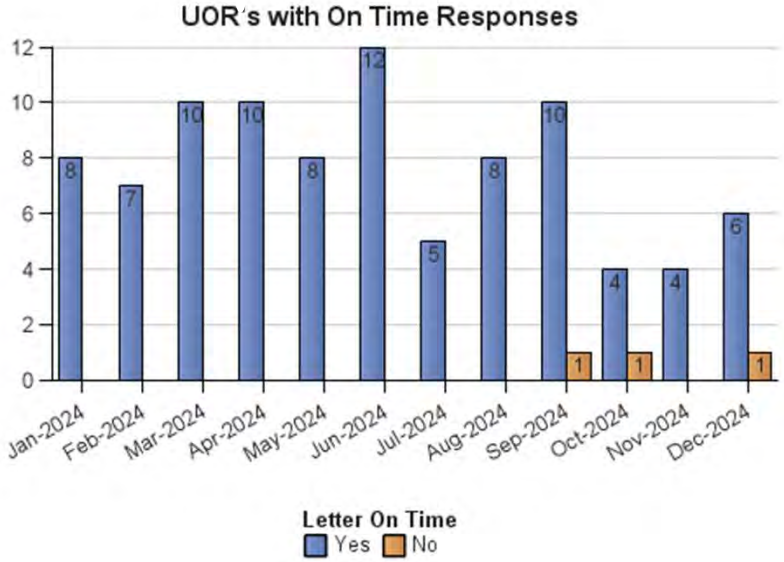

Problem at Processing
2024
Problem at processing
Yes
No
Item Count
MonthYear
Jan-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024


Problem at Receiving
2024
Problem a receiving
Yes
No
Item Count
MonthYear
Jan-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024

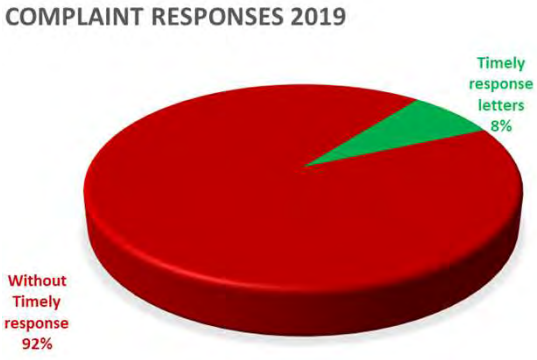

Problem During Review
2024
Problem during review
Yes
No
Item Count
MonthYear
Jan-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024

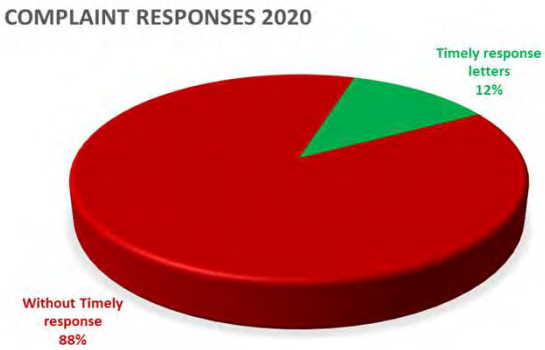


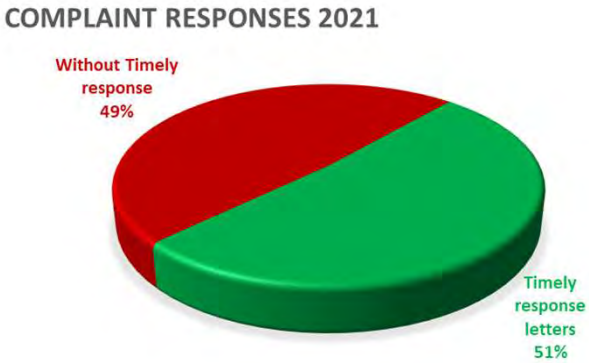
Jan-2024	8
Feb-2024	7
Mar-2024	10
Apr-2024	10
May-2024	8
Jun-2024	12
Jul-2024	5
Aug-2024	8
Sep-2024	11
Oct-2024	5
Nov-2024	4
Dec-2024	7
Total	**95**

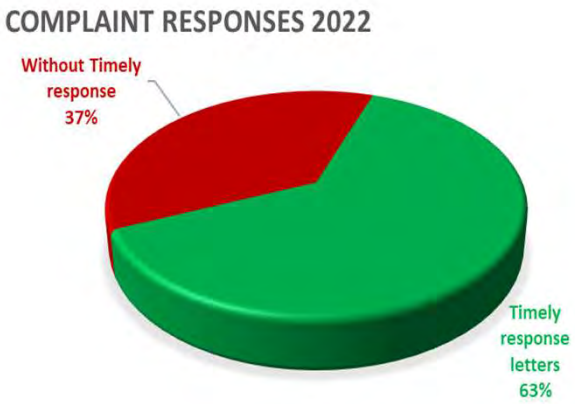


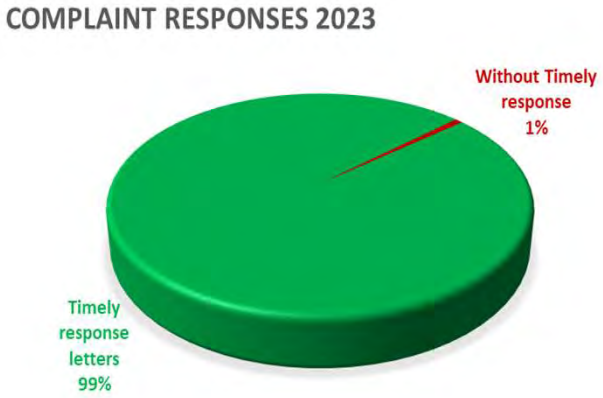
	Yes	No	Total
Jan-2024	8		**8**
Feb-2024	7		**7**
Mar-2024	10		**10**
Apr-2024	10		**10**
May-2024	8		**8**
Jun-2024	12		**12**
Jul-2024	5		**5**
Aug-2024	8		**8**
Sep-2024	10	1	**11**
Oct-2024	4	1	**5**
Nov-2024	4		**4**
Dec-2024	6	1	**7**
Total	**92**	**3**	**95**

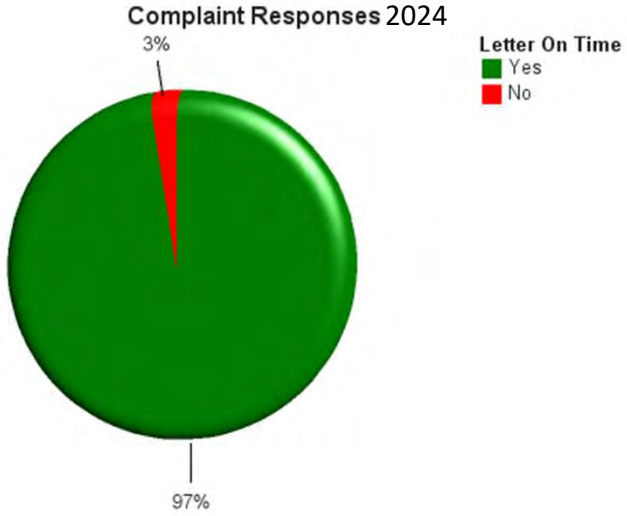






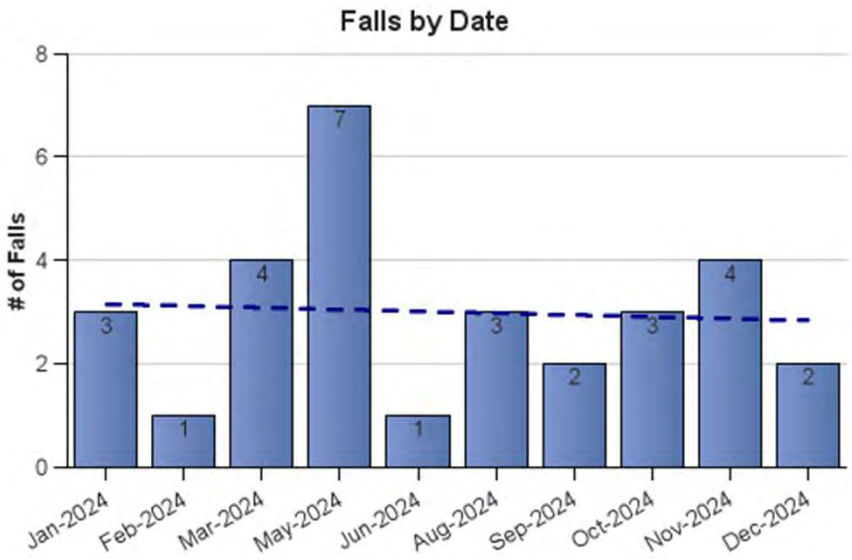






Goal is 100% Green (timely responses)

On average, a time frame of seven (7) business days for the provision of the response is the NIHD standard. (Requirement from NIHD POLICY)



# of Falls	Was there any injury?				
	Not Identified	Unknown	Yes	No	Total
Not Identified	8				8
ED	1		2	1	4
Inpatient		3		6	9
Outpatient	9				9
Total	**18**	**3**	**2**	**7**	**30**

# of Falls	Falls/Slip Problem(s)								Total
	Not Identified	Ambulating	Bathroom	Bed/Crib	Chair	Grounds/floor issues	Other	Other Person	
Not Identified	1	3	1	1	1	6	4	1	**18**
Confused		3	1						**4**
Oriented		4	5	1					**10**
Total	**1**	**10**	**7**	**2**	**1**	**6**	**4**	**1**	**32**

# of Falls	Falls/Slips	Total
Dietary	1	**1**
ED	4	**4**
EVS	1	**1**
Imaging	1	**1**
Medical Surgical Unit	9	**9**
OB	1	**1**
Other	5	**5**
Rehab Services - PT/OT/ST	6	**6**
Specialty Clinic	1	**1**
Surgery	1	**1**
Total	**30**	**30**

# of Falls	Was the Patient Assessed for Fall Risk		
	Not assessed	Yes	Total
Workforce	8		8
Outpatient	9		9
Inpatient		9	9
ED	1	3	4
Total	**18**	**12**	**30**

# of Falls	Was the Patient Assessed for Falls Protocol				
	Not assessed	Yes	Unknown	No	Total
Workforce	8				8
Outpatient	9				9
Inpatient		8	1		9
ED	1	2		1	4
Total	**18**	**10**	**1**	**1**	**30**

# of Falls	Received a Sedative w/in the Last 4 Hours			
	Not assessed	Yes	No	Total
Workforce	8			8
Outpatient	9			9
Inpatient		1	8	9
ED	1	1	2	4
Total	**18**	**2**	**10**	**30**

# of Falls	The Patient Is			
	Not assessed	Oriented	Confused	Total
Workforce	8			8
Outpatient	9			9
ED	1	3		4
Inpatient		6	3	9
Total	**18**	**9**	**3**	**30**

# of Falls	Activity Privileges		
	Not assessed	Ambulatory	Total
Workforce	8		8
ED	1	3	4
Inpatient		9	9
Outpatient	9		9
Total	**18**	**12**	**30**

# of Falls	Siderails			
	Not assessed	Siderails down	Siderails up	Total
Workforce	8			8
Outpatient	9			9
ED	1	2	1	4
Inpatient		2	7	9
Total	**18**	**4**	**8**	**30**

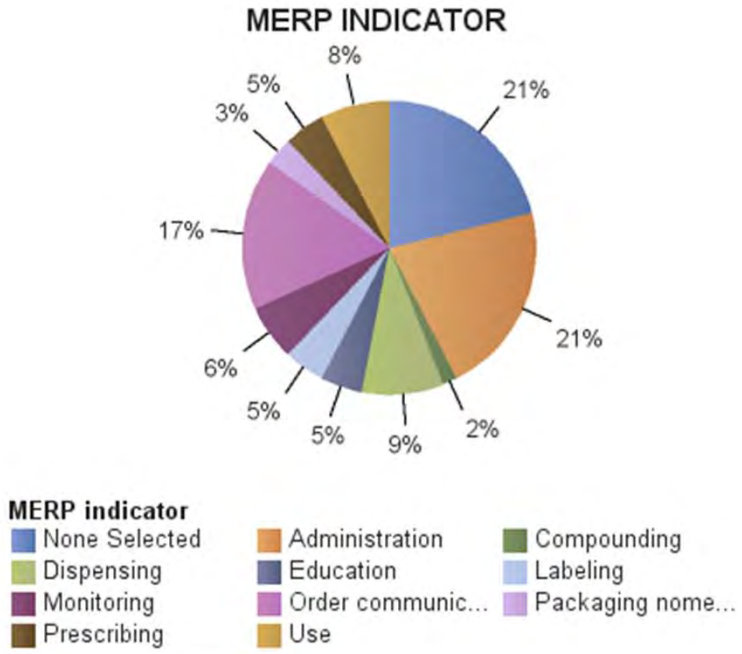
# of Falls	Restraints		
	Not assessed	None	Total
Workforce	8		8
Outpatient	9		9
Inpatient		9	9
ED	1	3	4
Total	**18**	**12**	**30**

# of Falls	Patient Attendent			
	Not assessed	Yes	No	Total
Workforce	8			8
Outpatient	9			9
Inpatient		3	6	9
ED	1	1	2	4
Total	**18**	**4**	**8**	**30**

# of Falls	Environment			
	Not assessed	No environmental concerns	Other	Total
Workforce	8			8
Outpatient	9			9
Inpatient		6	3	9
ED	1	3		4
Total	**18**	**9**	**3**	**30**

# of Falls	Fall Witnessed				Fall Alleged				Assisted to Floor				Found on Floor			
	Not Identified	No	Yes	Total	Not Identified	No	Yes	Total	Not Identified	No	Yes	Total	Not Identified	No	Yes	Total
Not Identified	8			8	8			8	8			8	8			8
ED	1	2	1	4	1	1	2	4	2	2		4	2		2	4
Inpatient	1	5	3	9	7		2	9	5	3	1	9	4	1	4	9
Outpatient	9			9	9			9	9			9	9			9
Total	**19**	**7**	**4**	**30**	**25**	**1**	**4**	**30**	**24**	**5**	**1**	**30**	**23**	**1**	**6**	**30**

Medication Error Reduction Plan (MERP)

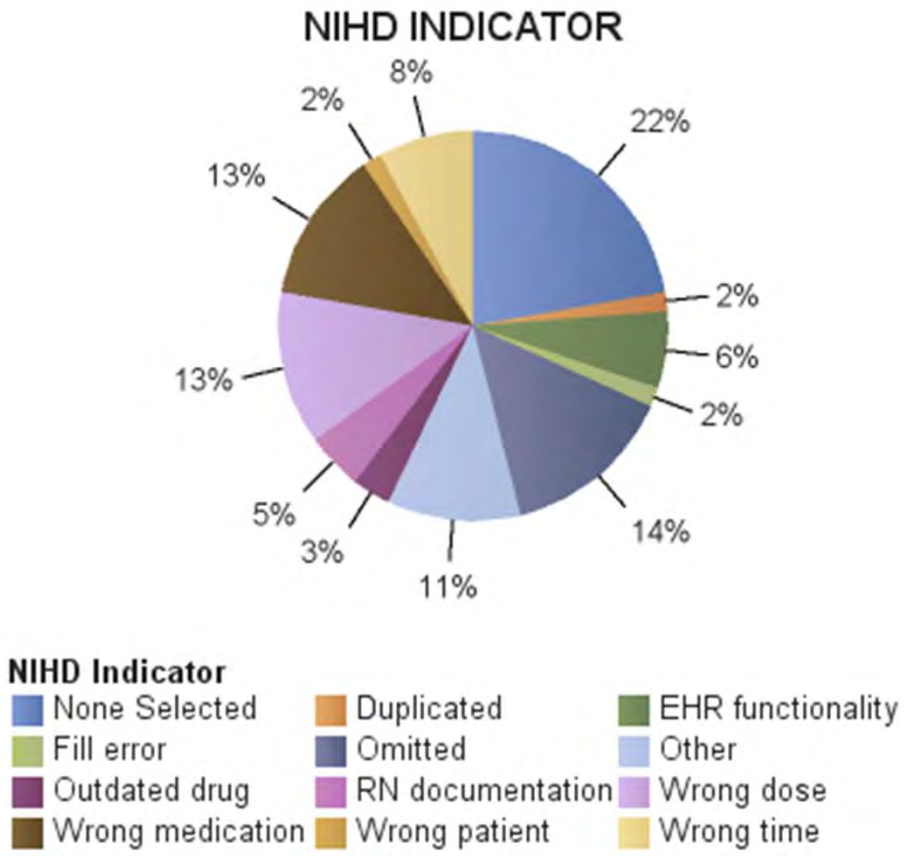


None Selected	14
Administration	14
Compounding	1
Dispensing	6
Education	3
Labeling	3
Monitoring	4
Order communication	11
Packaging nomenclature	2
Prescribing	3
Use	5
Total	**66**

	# of Errors	# of Occurrences	Total
Jan-2024	7	3	**10**
Feb-2024	4		**4**
Mar-2024	2	1	**3**
Apr-2024	2	1	**3**
May-2024	2	3	**5**
Jun-2024	4	3	**7**
Jul-2024	6	1	**7**
Sep-2024	6		**6**
Oct-2024	3	1	**4**
Nov-2024	4	1	**5**
Dec-2024	4		**4**
Total	**44**	**14**	**58**

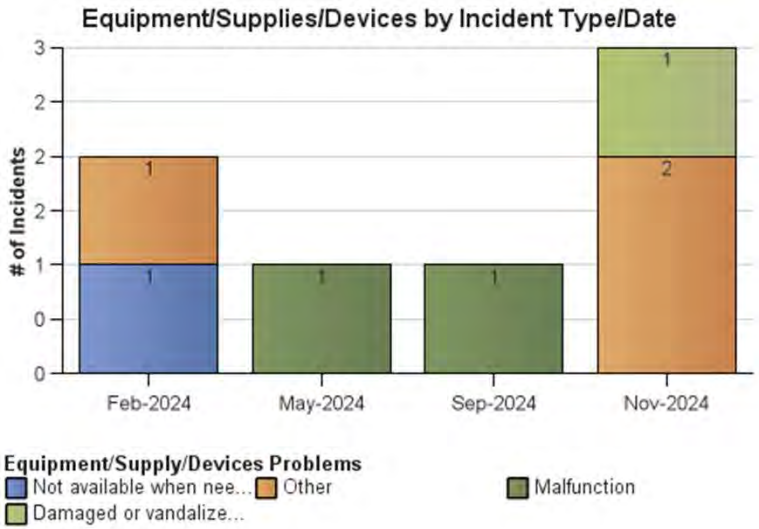
All medication errors and occurrences are reviewed by the Medication Administration Improvement Committee. The MERP and NIHD Indicators (following page) allow NIHD to categorize errors in order to focus on high frequency error reasons to create a plan for reduction.

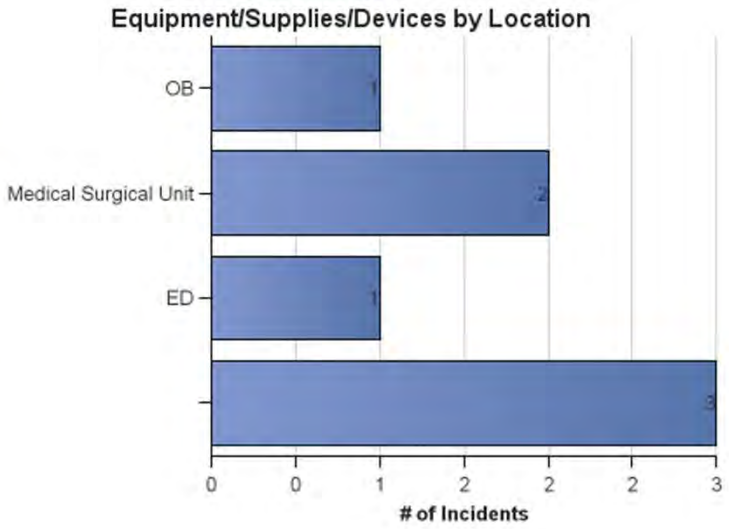
Medication errors are errors that reach the patient. Medication occurrences are errors that are caught before they reach the patient.



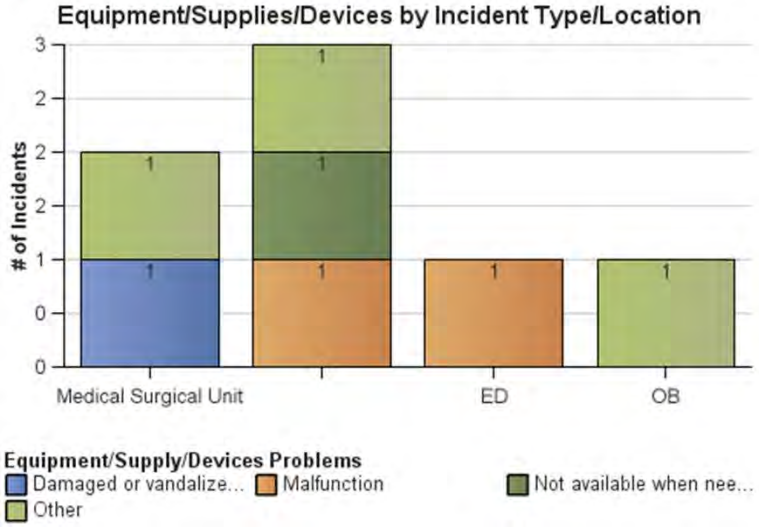
None Selected	14
Duplicated	1
EHR functionality	4
Fill error	1
Omitted	9
Other	7
Outdated drug	2
RN documentation	3
Wrong dose	8
Wrong medication	8
Wrong patient	1
Wrong time	5
Total	**63**

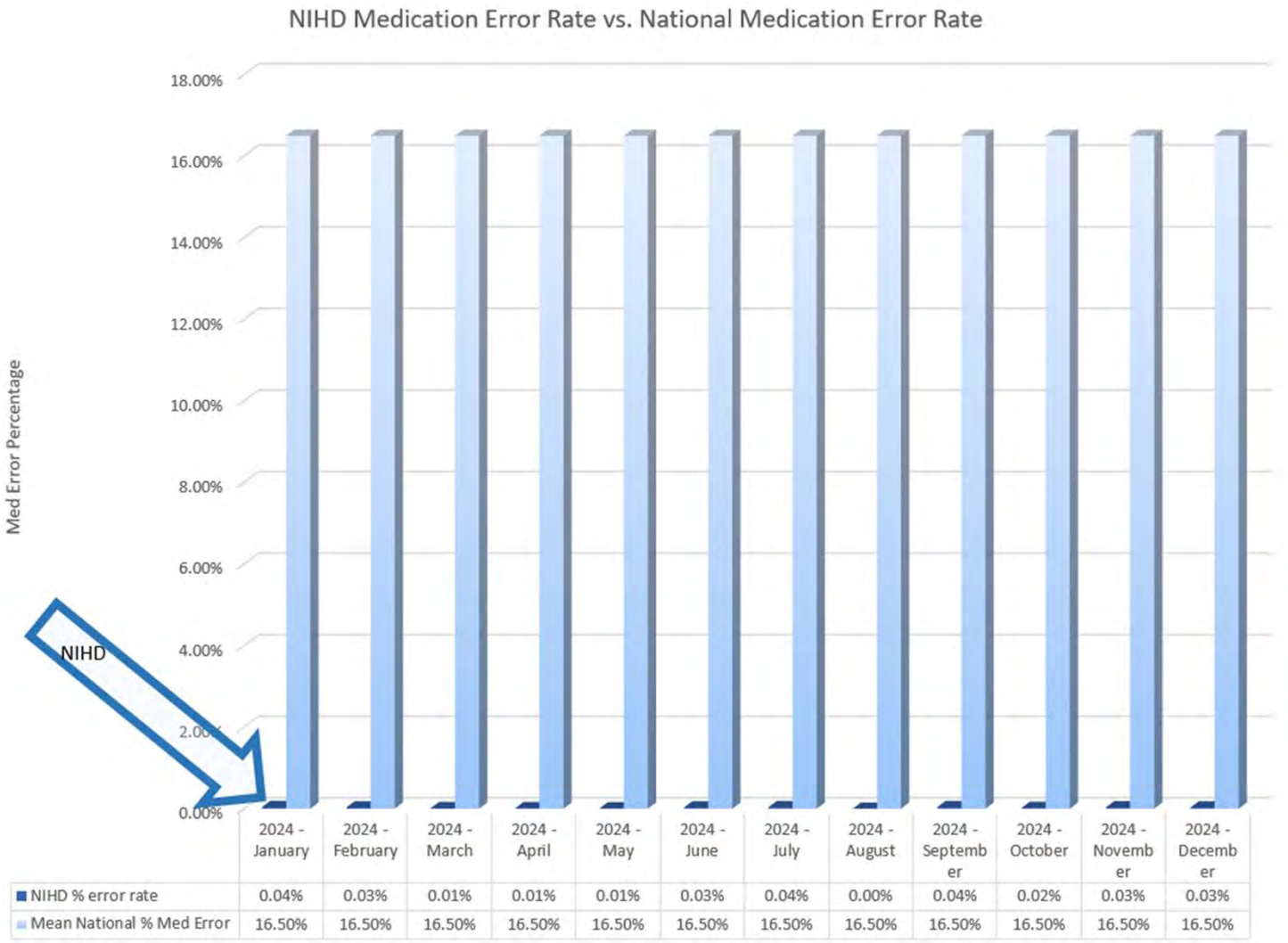
Total numbers of errors and occurrences are not equal to the indicators since some error/occurrences have more than one indicator.





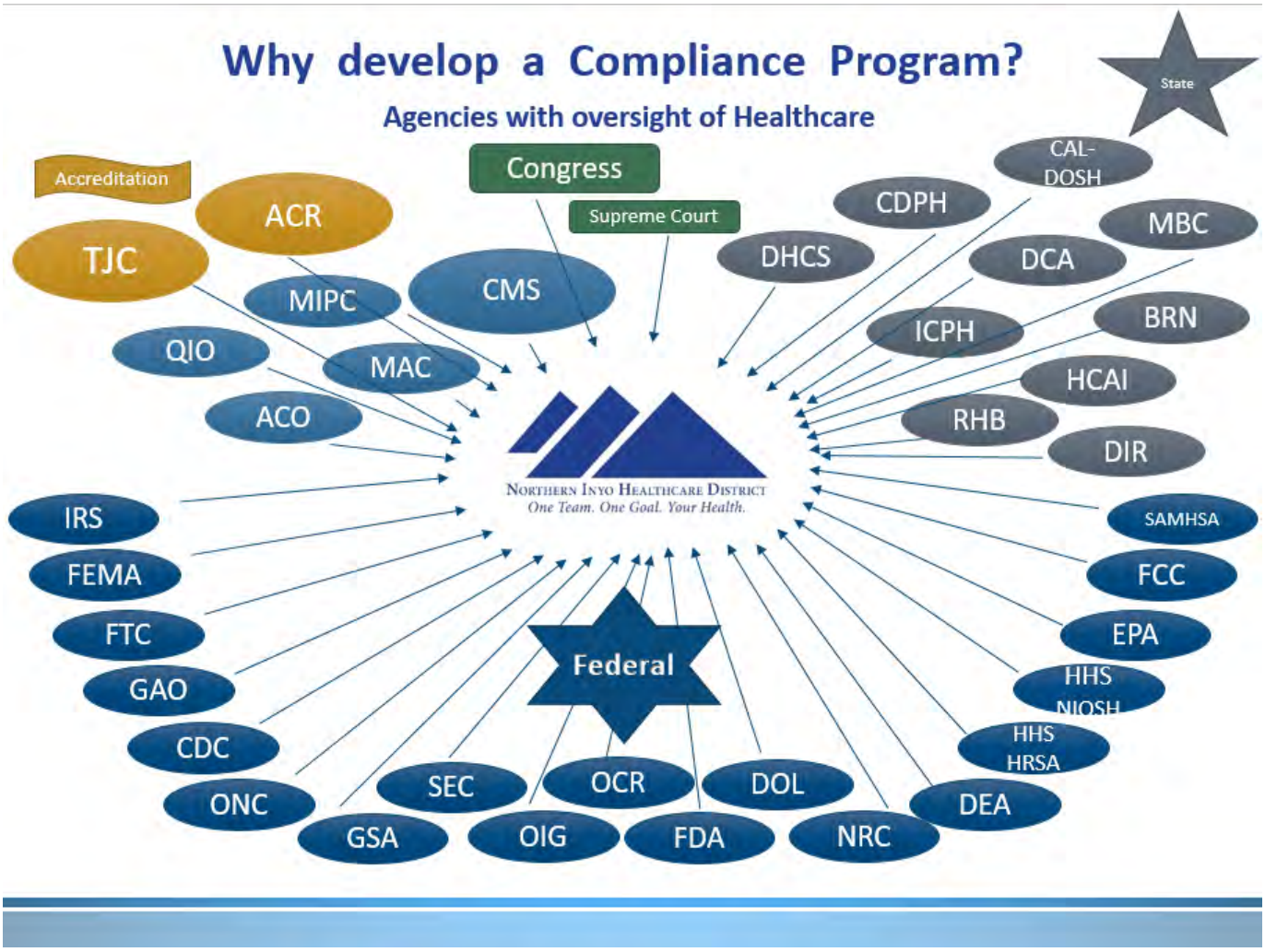
No Data Available




NIHD Medication Error Rate vs. National Medication Error Rate
Med Error Percentage
18.00%
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
NIHD
2024 - January
2024 - February
2024 - March
2024 - April
2024 - May
2024 - June
2024 - July
2024 - August
2024 - September
2024 - October
2024 - November
2024 - December
NIHD % error rate 0.04% 0.03% 0.01% 0.01% 0.01% 0.03% 0.04% 0.00% 0.04% 0.02% 0.03% 0.03%
Mean National % Med Error 16.50% 16.50% 16.50% 16.50% 16.50% 16.50% 16.50% 16.50% 16.50% 16.50% 16.50% 16.50%

Data for previous slide

Month/Year	Total number of Medications administered	NIHD Total number of errors	NIHD % error rate	National % Medication Error	Mean National % Med Error	NIHD % Medication Administration accuracy	References
2024 - January	16,772	7	0.04%	8%-25%	16.50%	99.96%	In a review of 91 direct observation studies of medication errors in hospitals and long-term care facilities, investigators estimated median error rates of 8%–25% during medication administration.
2024 - February	12,671	4	0.03%	8%-25%	16.50%	99.97%	
2024 - March	13,815	2	0.01%	8%-25%	16.50%	99.99%	
2024 - April	14,886	2	0.01%	8%-25%	16.50%	99.99%	reference for above: https://psnet.ahrq.gov/primer/medication-administration-errors#:~:text=In%20a%20review%20of%2091,%E2%80%9325%25%20during%20medication%20administration.
2024 - May	15,273	2	0.01%	8%-25%	16.50%	99.99%	Occurrences not included, as they are not errors that are administered to a patient.
2024 - June	12,566	4	0.03%	8%-25%	16.50%	99.97%	
2024 - July	16,173	6	0.04%	8%-25%	16.50%	99.96%	
2024 - August	15,416	0	0.00%	8%-25%	16.50%	100.00%	
2024 - September	16,250	6	0.04%	8%-25%	16.50%	99.96%	
2024 - October	14,778	3	0.02%	8%-25%	16.50%	99.98%	
2024 - November	11,959	4	0.03%	8%-25%	16.50%	99.97%	
2024 - December	12,532	4	0.03%	8%-25%	16.50%	99.97%	



YouCompli

In December 2024, Northern Inyo Healthcare District began implementing YouCompli. YouCompli will assist the Compliance team with knowing about and being prepared for regulatory changes from the regulators in the image above.

The software program uses AI technology to comb regulatory bodies for changes to regulations, laws, and formal guidance. Legal scholars and specialists then review the changes and develop questions to allow our department leadership teams to determine if the regulation applies to our facility and departments. Once determined to be relevant, the program contains the changes in the regulatory language and areas to document our policy, operational, and procedural plans to ensure compliance with the changes.

As part of the implementation project, we have reviewed changes with effective dates prior to January 1, 2025 to ensure compliance.

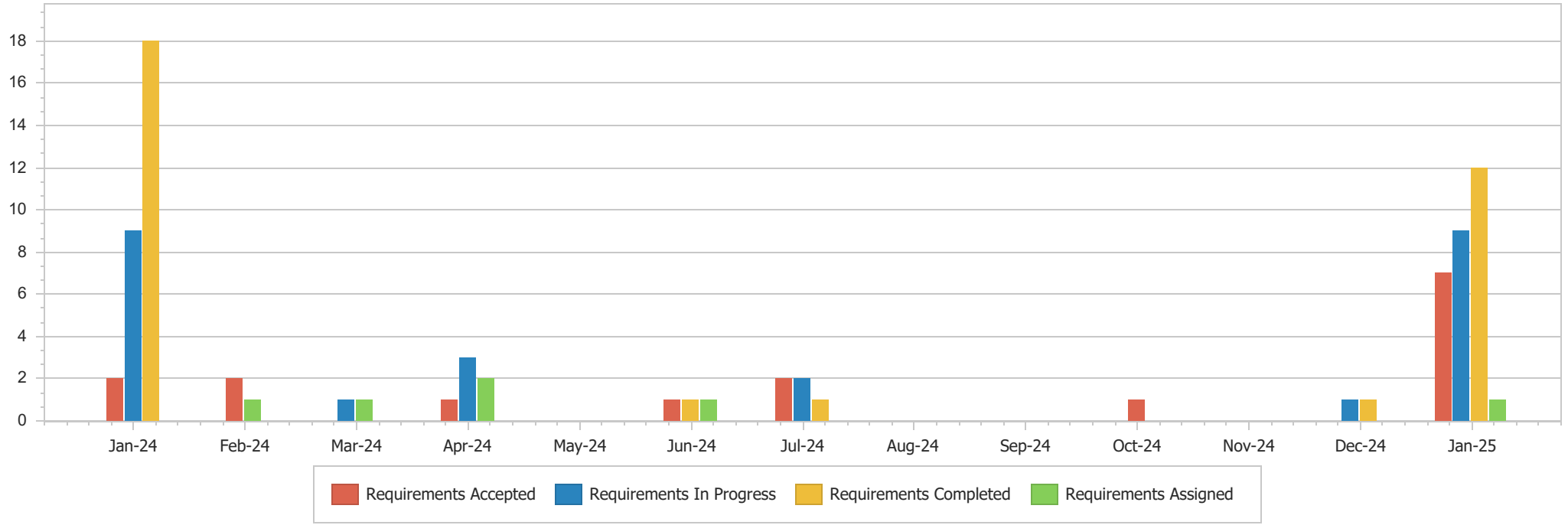
The following pages contain the agencies constantly monitored for changes that may affect Northern Inyo Healthcare District.

Agency for Healthcare Research & Quality (AHRQ)
CA Physician Assistant Board
California Board of Behavioral Sciences
California Board of Registered Nursing
California Department of Consumer Affairs
California Department of Health Care Access and Information
California Department of Health Care Services (Medi-Cal)
California Department of Managed Health Care
California Department of Managed Health Care Services - BHIN
California Department of Public Health
California Health and Human Services Agency
California Health Facilities Financing Authority
California Office of Administrative Law
California Office of Statewide Health Planning and Development
California State and Consumer Services Agency
California State Assembly
California State Board of Pharmacy
Centers for Disease Control & Prevention (CDC)
Centers for Medicare & Medicaid Services (CMS)

Clinical Laboratory Improvement Amendments (CLIA)
CMS - Center for Clinical Standards and Quality
Department of Commerce (DoC)
Department of Defense (DoD)
Department of Energy
Department of Health & Human Services (HHS)
Department of Justice (DOJ)
Department of Labor (DOL)
Department of Transportation (DOT)
Department of Veteran's Affairs
Drug Enforcement Administration (DEA)
Employee Benefits Security Administration
Environmental Protection Agency (EPA)
Federal Aviation Administration (FAA)
Federal Communications Commission (FCC)
Federal Trade Commission (FTC)
Food & Drug Administration (FDA)
Health Resources and Services Administration (HRSA)
Internal Revenue Service (IRS)
JD Noridian
JE Noridian
Medical Board of California
Medicare Program Integrity Contractors
National Institutes of Health (NIH)
Nuclear Regulatory Commission (NRC)
Occupational Safety & Health Administration (OSHA)
Occupational Safety and Health Division
Office for Civil Rights (OCR)
Office of Diversion Control (DOJ-ODC)
Office of Inspector General (OIG)
Office of Labor Management & Standards (OLMS)
Office of the National Coordinator for Health Information Technology (ONC)
Securities & Exchange Commission (SEC)
State of California Department of Justice (Attorney General)
Substance Abuse and Mental Health Services Administration (SAMHSA)
The National Institute for Occupational Safety and Health (NIOSH)
Treasury (TREASURY)
US Congress (USC)
US State Department Office of Civil Rights (S/OCR)
Wage & Hour Division (WHD)

YouCompli
FROM CHAOS TO CONFIDENCE

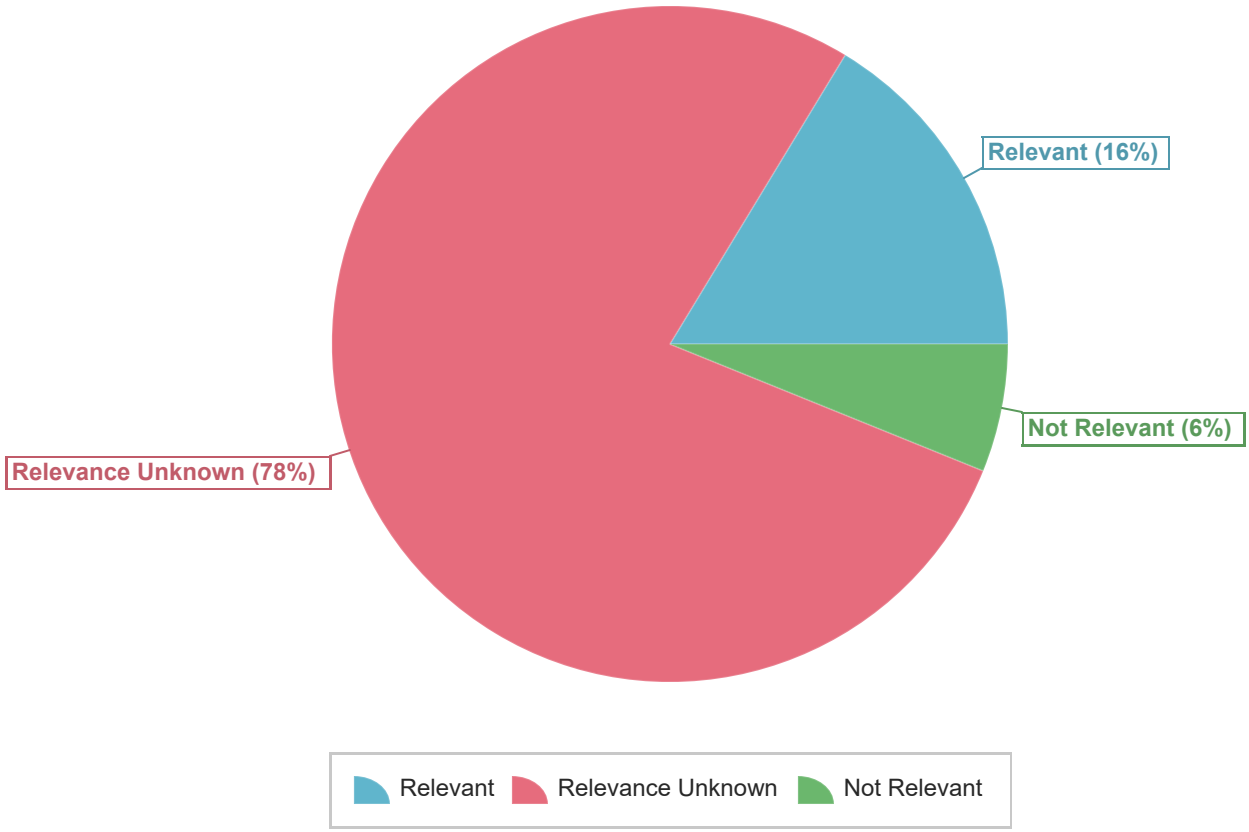
Requirement Status Overview by Month



Effective Date

Status	Jan-24	Feb-24	Mar-24	Apr-24	Jun-24	Jul-24	Oct-24	Dec-24	Jan-25	Total
Accepted	2	2		1	1	2	1		7	16
Assigned		1	1	2	1				1	6
Completed	18				1	1		1	12	33
In Progress	9		1	3		2		1	9	25
Total	29	3	2	6	3	5	1	2	29	80

Requirement Relevance Overview



Effective Dates : 09/01/2024 - 01/31/2025	
Requirement Total	196
Relevant	32
Not Relevant	12
Relevance Unknown	152

Examples of Regulatory Updates that are relevant and in progress in the YouCompli System:

Update Procedures Related to Licensing and Reporting Under the Health and Safety Code

Requirement ID #2180
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: In Progress, Status Date: 01/27/2025
Description: Organizations should update procedures related to licensing and reporting under the Health and Safety Code.
Regulation 2074 » Requirement 2180

Update Procedures for Determining Immediate Jeopardy

Requirement ID #2200
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 12/13/2024
Status: In Progress, Status Date: 01/27/2025
Description: Providers should update procedures to reflect updated requirements for determining immediate jeopardy.
Regulation 2146 » Requirement 2200

Update Procedures for Safeguarding Conscience Rights in Health Care

Requirement ID #1823
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 03/11/2024
Status: In Progress, Status Date: 12/19/2024
Description: Organizations should update procedures related to safeguarding conscience rights in health care.
Regulation 1777 » Requirement 1823

Update Procedures Related to the Execution of Informed Consent Forms Before Surgery and Sensitive Procedures

Requirement ID #1919
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 04/19/2024
Status: Accepted, Status Date: 12/13/2024
Description: Organization should update procedures to reflect revisions to the informed consent form example for surgical procedures and sensitive examinations.
Regulation 1873 » Requirement 1919

Update Procedures Related to Billing and Coding for MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing

Requirement ID #1989
Risk Category: Revenue Cycle
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 07/01/2024
Status: Accepted, Status Date: 12/13/2024
Description: Organizations should update their procedures to reflect updated billing and coding guidance for MolDX: molecular syndromic panels for infectious disease pathogen identification testing.
Regulation 1943 » Requirement 1989

Update Procedures for Suicide Screenings in General Acute Care Hospitals

Requirement ID #1224
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 12/16/2024
Description: Organizations should update procedures for suicide screenings in general acute care hospitals.
Regulation 1190 » Requirement 1224

Update Procedures Related to Earthquake Building Compliance

Requirement ID #2122
Risk Category: Capital and Facilities Management
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 12/16/2024
Description: Organizations should update procedures related to earthquake building compliance.
Regulation 2072 » Requirement 2122

Update Procedures Related to Disclosure of HIV Records

Requirement ID #2123
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 12/16/2024
Description: Organizations should update procedures related to the disclosure of HIV records.
Regulation 2073 » Requirement 2123

Update Procedures Related to Vital Records

Requirement ID #2124
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 12/16/2024
Description: Organizations should update procedures related to vital records.
Regulation 2074 » Requirement 2124

Update Procedures Related to Tuberculosis Tests and Care

Requirement ID #2147
Risk Category: Clinical Care Delivery
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 12/16/2024
Description: Organizations should update procedures related to tuberculosis tests and care.
Regulation 2097 » Requirement 2147

Update Procedures Related to Hospitals Requirements to Submit Plans for Increasing Supplier Diversity

Requirement ID #1698
Risk Category: Supply Chain / Procurement
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2024
Status: Accepted, Status Date: 12/19/2024
Description: Organization should update procedures to reflect revisions to the requirements for hospitals to submit plans for increasing supplier diversity.
Regulation 1655 » Requirement 1698

Update Procedures Related to the Hospital Fair Billing Program

Requirement ID #1753
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2024
Status: Accepted, Status Date: 12/19/2024
Description: Organization should update procedures to reflect revisions to the hospital fair billing program.
Regulation 1708 » Requirement 1753

Update Procedures for Texting of Patient Information and Orders for Hospitals and CAHs

Requirement ID #1828
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 02/08/2024
Status: Accepted, Status Date: 12/19/2024
Description: Organizations should update procedures to reflect CMS' expectations regarding the texting of patient information and orders for hospitals and critical access hospitals.
Regulation 1782 » Requirement 1828

Update Procedures Related to Hybrid Hospital-Wide Inpatient Quality Reporting Program

Requirement ID #2193
Risk Category: Quality/Performance Improvement
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 12/30/2024
Description: Organization should update procedures to reflect revisions to the voluntary inpatient quality reporting program.
Regulation 2138 » Requirement 2193

Update Procedures for Human Leukocyte Antigen (HLA) Equivalency Tables

Requirement ID #2207
Risk Category: Transplant
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 12/05/2024
Status: Accepted, Status Date: 01/13/2025
Description: Organizations should revise their procedures regarding the Human Leukocyte Antigen (HLA) Equivalency tables.
Regulation 2153 » Requirement 2207

Update Procedures for Time-share and Leased Space Arrangements in Critical Access Hospitals (CAHs)

Requirement ID #2211
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 11/20/2024
Status: Accepted, Status Date: 01/17/2025
Description: Providers should update procedures regarding requirements for time-share and leased space arrangements in Critical Access Hospitals (CAHs).
Regulation 2157 » Requirement 2211

Update Procedures Regarding Health Data, Technology, and Interoperability: Protecting Care Access

Requirement ID #2221
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 12/17/2024
Status: Accepted, Status Date: 01/24/2025
Description: Organizations should update procedures regarding the Health Data, Technology, and Interoperability: Patient Engagement, Information Sharing, and Public Health Interoperability final rule (HTI–2 Rule).
Regulation 2167 » Requirement 2221

Copy of Update Procedures for CY 2025 Physician Fee Schedule Reporting and Returning Overpayments

Requirement ID #2224
Risk Category: Revenue Cycle
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 01/27/2025
Description: Organizations should update procedures regarding the reporting and returning of overpayments.
Regulation 2126 » Requirement 2224

Update Procedures Related to Nonrecurring Policy Changes

Requirement ID #2187
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 01/27/2025
Description: Organization should update procedures to reflect revisions to nonrecurring policy changes.
Regulation 2134 » Requirement 2187

Update Procedures for Data Collection on Vascularized Composite Allografts (VCA) Living Donors

Requirement ID #2225
Risk Category: Transplant
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 12/11/2024
Status: Accepted, Status Date: 01/28/2025
Description: Organizations should update procedures regarding modifying data collection on vascularized composite allografts (VCA) living donors.
Regulation 2170 » Requirement 2225

Update Procedures for Health Data Information Sharing

Requirement ID #1805
Risk Category: Health Care Reform-Related Risks
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 02/08/2024
Status: Accepted, Status Date: 01/29/2025
Description: Organizations should update procedures and/or be aware of enhancements regarding information blocking regulations.
Regulation 1759 » Requirement 1805

Update Procedures for Confidentiality of Substance Use Disorder Patient Records Revisions

Requirement ID #1838
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 04/16/2024
Status: Accepted, Status Date: 01/29/2025
Description: Organizations should update procedures for the confidentiality of substance use disorder patient records.
Regulation 1792 » Requirement 1838

Update Procedures for HIPAA Privacy Rule and Reproductive Health Care

Requirement ID #1915
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 06/25/2024
Status: Accepted, Status Date: 01/29/2025
Description: Organizations should update procedures for HIPAA Privacy Rule changes that prohibit the disclosure of PHI related to lawful reproductive health care in certain circumstances.
Regulation 1869 » Requirement 1915

Update Procedures Related to ESRD Prospective Payment System (PPS) and Dialysis for AKI (CY) 2025

Requirement ID #2235
Risk Category: Revenue Cycle
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 01/30/2025
Description: Organizations should update their procedures for ESRD PPS and dialysis services provided for AKI for CY 2025.
Regulation 2178 » Requirement 2235

Update Procedures Related to Nondiscrimination in Health Programs and Activities

Requirement ID #1932
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 07/05/2024
Status: Accepted, Status Date: 01/31/2025
Description: Organization should update procedures to reflect revisions to nondiscrimination in health programs and activities.
Regulation 1886 » Requirement 1932

Update Procedures Related to Nondiscrimination on the Basis of Disability in Health Programs and Activities

Requirement ID #1937
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 07/08/2024
Status: Accepted, Status Date: 01/31/2025
Description: Organization should update procedures to reflect revisions to nondiscrimination on the basis of disability in health programs and activities
Regulation 1891 » Requirement 1937

Update Procedures for Nondiscrimination in Health Programs or Activities

Requirement ID #479
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 08/18/2020
Status: Accepted, Status Date: 01/31/2025
Description: Organizations should update procedures to ensure that individuals are not discriminated against based on race, color, national origin, sex, age, or disability.
Regulation 457 » Requirement 479

Update Procedures for Condition of Participation (CoP) Requirements for Hospitals and Critical Access Hospitals (CAHs) To Report Acute Respiratory Illnesses

Requirement ID #2141
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 10/22/2024
Status: Accepted, Status Date: 01/31/2025
Description: Organizations should update procedures regarding Condition of Participation (CoP) requirements for hospitals and Critical Access Hospitals (CAHs) to report acute respiratory illnesses.
Regulation 2091 » Requirement 2141

FYI - Calendar Year (CY) 2025 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

Requirement ID #2238
Risk Category: Revenue Cycle
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 01/31/2025
Description: CMS has updated the CY 2025 clinical laboratory fee schedule and laboratory services subject to reasonable charge payment.
Regulation 2181 » Requirement 2238

FYI - Billing for Care Coordination Services for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Requirement ID #2239
Risk Category: Revenue Cycle
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 01/31/2025
Description: CMS has updated the billing for care coordination services for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).
Regulation 2182 » Requirement 2239

Update Procedures for Designation of Pharmacist-In-Charge

Requirement ID #2240
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 04/01/2025
Status: Accepted, Status Date: 02/03/2025
Description: Organizations should update procedures for revised pharmacist-in-charge-requirements at pharmacies.
Regulation 2183 » Requirement 2240

FYI - Calendar Year 2025 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

Requirement ID #2242
Risk Category: Revenue Cycle
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 02/03/2025
Description: CMS has updated the calendar year 2025 DMEPOS fee schedule.
Regulation 2185 » Requirement 2242

Update Procedures for Implementation of ESRD Prospective Payment System (PPS) and Dialysis for Individuals with AKI (CY) 2025

Requirement ID #2253
Risk Category: Revenue Cycle
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 02/05/2025
Description: Organizations should update their procedures for ESRD PPS and dialysis services provided for individuals with acute kidney injury (AKI).
Regulation 2196 » Requirement 2253

Update Procedures Regarding Billing Requirements for Intensive Outpatient Program (IOP) Services for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Requirement ID #2256
Risk Category: Revenue Cycle
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 02/05/2025
Description: Organizations should revise their procedures to reflect the billing requirements for Intensive Outpatient Programs (IOP) when up to 3 services are provided, as well as when 4 or more IOP services are performed.
Regulation 2199 » Requirement 2256

NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.

DATE: March 2025

TO: Board of Directors, Northern Inyo Healthcare District (NIHD)

FROM: Robin Christensen BSN, RN, HIC Manager Infection Preventions/Employee Health

RE: Infection Preventions/Employee Health FY 2025 Q2

Introduction
This report provides an update on the NIHD ongoing infection prevention and employee health initiatives. The purpose is to keep the Board of Directors informed about NIHD continuous efforts, recent outcomes, and plans aimed at maintaining a healthy safe environment and workplace for all patients, staff members and visitors.

The Infection Prevention (IP) and Employee Health (EH) teams are dedicated to promoting and implementing evidence-based practices (EBPs) related to the prevention and control of infections, ensuring the safety of both patients and employees. The IP & EH teams emphasize the importance of infection control and employee health strategies, recognizing that these are everyone's responsibility. It is essential for all staff to prioritize these efforts in order to protect patients from preventable Hospital-Associated Infections (HAIs) and ensure employees contribute to maintaining a safe environment by following safety protocols and reporting hazards.

Focus Areas:
Infection Prevention

a. Review Hospital-Acquired Infections Data Related to Surgical Site Infections, Device-Associated Infections, and Multi-Drug Resistant Reporting to NHSN
b. Track and trend Antibiotic Stewardship Activities and its impact on District patients.
c. Review Employee Sharps Injury Data

Employee Health

a. Review Healthcare-Worker Influenza Vaccination Rates
b. Review Employee Safe Patient Handling (SPH) Injuries

Key Outcomes and Next Steps

1. Infection Prevention:
    a. HAI:
        - **Ensure Timely NHSN Reporting:** Continue to monitor and ensure that all NHSN-required data is submitted on time, particularly focusing on the accurate reporting of infection rates for compliance with Centers for Medicare & Medicaid Services (CMS) requirements.

- **Review and Update Protocols:** Conduct a comprehensive review of current infection control protocols to ensure they align with the latest evidence-based practices (EBP) and regulatory requirements.
    - Evidenced-based practices will include the Society for Healthcare Epidemiology of America (SHEA) Compendium of Strategies to Prevent HAIs in Acute Care Hospitals. With initial focus on prevention of:
        - Prevention of device-associated infections
        - Prevention of Clostridioides difficile infections (CDI)
        - Prevention of surgical site infections (SSI)
        - Prevention of multi-drug resistant organisms (MDROs) through transmission based precautions and hand hygiene
- Continue tracer activities and department rounding
- Identified hospital-onset C-diff FY 2025 Q2. Patient high risk for developing C-diff. Action plan is to educate clinical teams on risk factors. See ATB Stewardship section for further details.

b. Antibiotic Stewardship Activities:

- Strengthen Antibiotic Stewardship Programs: Further promote antibiotic stewardship initiatives to prevent the overuse of antibiotics, which contributes to the emergence of resistant infections.
- Met 2024 annual goals See report.
- Next step is to create 2025 annual goals, which will be presented at next CQSR committee meeting. One key objective for 2025 is to create C. diff order sets and provide education to clinical staff on their use.
- Continue to meet quarterly and report monthly antibiotic use (AU) & antibiotic resistance (AR) patterns.
- Will continue to monitor the 2024 goal on decreasing mixed flora urine cultures.
- The team worked together to complete the required CMS/NHSN 2024 annual survey, and the information has been successfully submitted. Notably, we were able to answer "yes" to all the options indicating that facility leadership is committed to Antibiotic Stewardship (ATB) efforts. In 2023, we were able to meet only five of these options. Please see the attached screenshot for more details.

Antibiotic Stewardship Practices
(completed with input from Physician and Pharmacist Stewardship Leaders)

41. * Facility leadership has demonstrated a commitment to antibiotic stewardship efforts by: (Check all that apply)

- ☑ Providing stewardship program leader(s) dedicated time to manage the program and conduct daily stewardship interventions
- ☑ Allocating resources (for example, IT support, training for stewardship team) to support antibiotic stewardship efforts
- ☑ Having a senior executive that serves as a point of contact or "champion" to help ensure the program has resources and support to accomplish its mission
- ☑ Presenting information on stewardship activities and outcomes to facility leadership and/or board at least annually
- ☑ Ensuring the stewardship program has an opportunity to discuss resource needs with facility leadership and/or board at least annually
- ☑ Communicating to staff about stewardship activities, via email, newsletters, events, or other avenues
- ☑ Providing opportunities for hospital staff training and development on antibiotic stewardship
- ☑ Providing a formal statement of support for antibiotic stewardship (for example, a written policy or statement approved by the board)
- ☑ Ensuring that staff from key support departments and groups (for example, IT and hospital medicine) are contributing to stewardship activities
- ☐ None of the above

c. **Sharps Injury:**
- There have been no sharps injuries reported for the year 2025 marking an achievement in our ongoing efforts to enhance safety protocols and prevent sharps-related incidents.
- Ongoing Education and Training: Continue to provide education on sharps safety and proper disposal techniques to maintain a high level of awareness and compliance among staff.
- Enhance Safety Protocols: We continue to explore additional engineered sharps safety devices for sharps injury prevention.

2. Employee Health:
   a. **HCW Influenza Vaccination Rates:**
   - Continue to educate staff on the importance of receiving the seasonal influenza vaccine.
   - NIHD offers a free influenza vaccine to all NIHD workforce members.
   - Continue sending weekly reminders to workforce members who have not provided influenza vaccination information or a declination.
   - Infection Prevention continues to report respiratory illnesses to Inyo County Public Health on a weekly basis.
   - As of February 21, 2025, the (HCW) influenza vaccination rate 80%.

Flu stats as of 2/21/25		
Total NIH HCW (Employees, Providers, Contracted Workers on site, Students, Volunteers)	**632**	
Flu Vaccinated	505	80%
Signed Declinations	69	11%
Medically Contraindicated	3	0.4%
Unknown: • Employees 17 • Providers 26 • Travelers 1 • Separated 9 • Volunteers 2	55	8.6%

   b. **SPH Injuries:**
   - On February 19, 2025, a **Train-the-Trainer** class was held for Clinical Staff Educators (CSEs) and department leads. A make-up course was offered on March 5, 2025. The trainers were Marcia Male Employee Health Nurse Specialist, Joanne Henze Director of Rehab, Marjorie Routt Manager Human Resources.
   - CSEs continue to train new clinical workforce members upon hire and provide annual skills day training within their respective departments
   - The Employee Health team, with assistance from Lynda Vance**,** developed a Safe Patient Handling (SPH) Dashboard. This dashboard includes training plans for all departments, new hire orientation, and department-specific safe patient handling equipment. The SmartSheet also stores SPH agendas and meeting minutes, making the information more easily accessible.

Regulatory Reporting and Requirements

Infection Prevention:

The Centers for Medicare & Medicaid Services (CMS) requires healthcare facilities participating in the Inpatient Quality Reporting Program to complete the National Healthcare Safety Network (NHSN) Annual Facility Survey by March 1st each year. This survey collects essential data on facility characteristics, infection prevention practices, and patient demographics, which are used for risk adjustment in generating Standardized Infection Ratios (SIRs).

Ensuring timely submission by the deadline is crucial, as failure to do so will result in the inability to enter new monthly reporting plans until the survey is completed.

a. HAI Reporting Compliance: The infection prevention team continues to meet all required reporting deadlines for NSHN**,** ensuring that data on key infections (e.g., CLABSI, CAUTI, and SSI) is submitted accurately and on time to comply with federal and state reporting requirements.
b. Successfully attested to 2024 Promoting Interoperability Antibiotic Use and Resistance.
c. Sharps Injuries: Please refer to the **2020-2024 Sharps Injury Data** for a detailed comparison of past trends and the effectiveness of our prevention measures over the years. The data demonstrates a reduction in sharps injuries, reflecting the success of our targeted interventions and employee safety programs.
d. Sharp Injuries: Our internal reporting system remains in place, with committee reviews and updates to ensure that all data is accurately collected, tracked, and addressed.

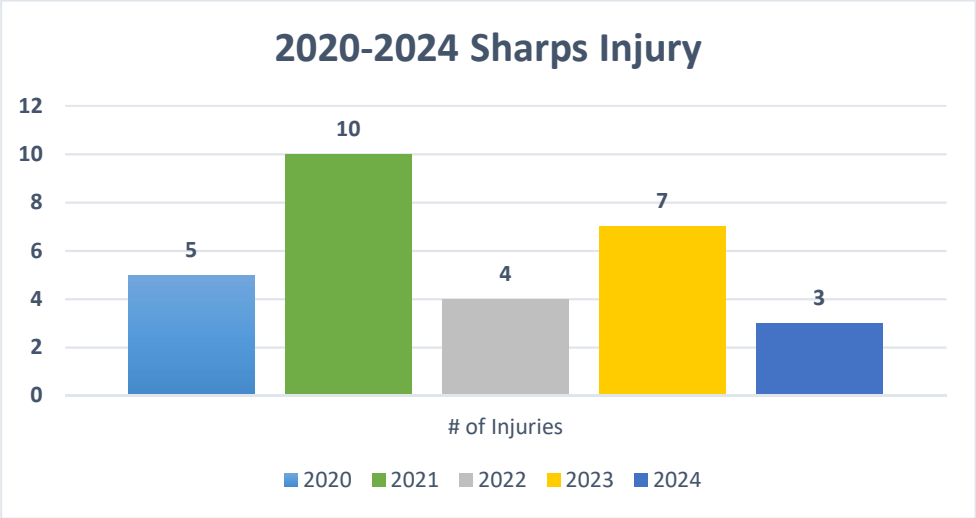
Employee Health:

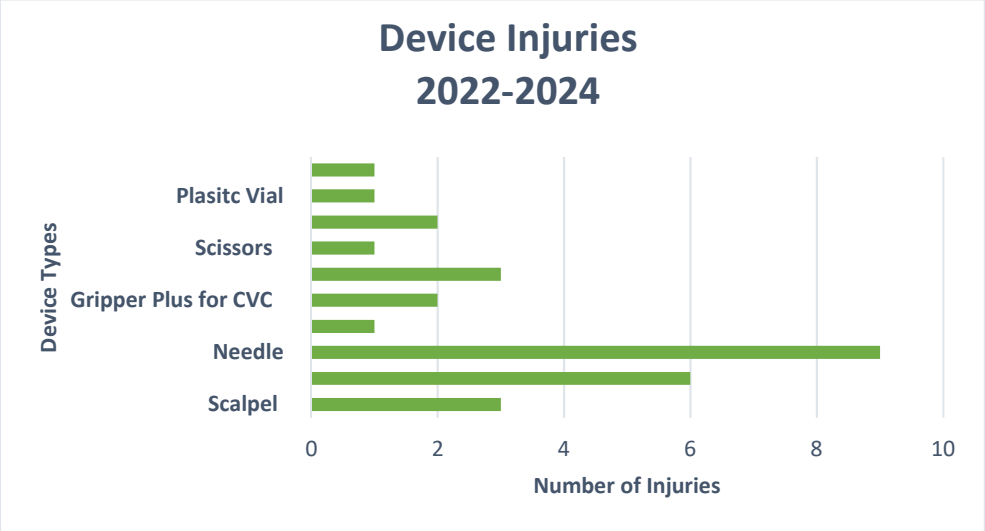
a. Influenza Vaccination
    - The reporting period for the 2024-2025 influenza season is from **October 1, 2024, to March 31, 2025**.
    - To comply with CMS (Centers for Medicare & Medicaid Services) reporting requirements, Healthcare Provider (HCP) influenza vaccination summary data must be entered into NSHN by **May 15, 2025**.
b. Safe Patient Handling (SPH) Injuries:
    - SPH injuries are reported monthly to both the Safety Committee and the SPH Committee.
    - All SPH injuries are also reported to Human Resources for OSHA injury tracking and compliance.
    - Departments that provide direct patient care ensure that employees receive SPH training upon hire, annually, and when any new SPH equipment is introduced.

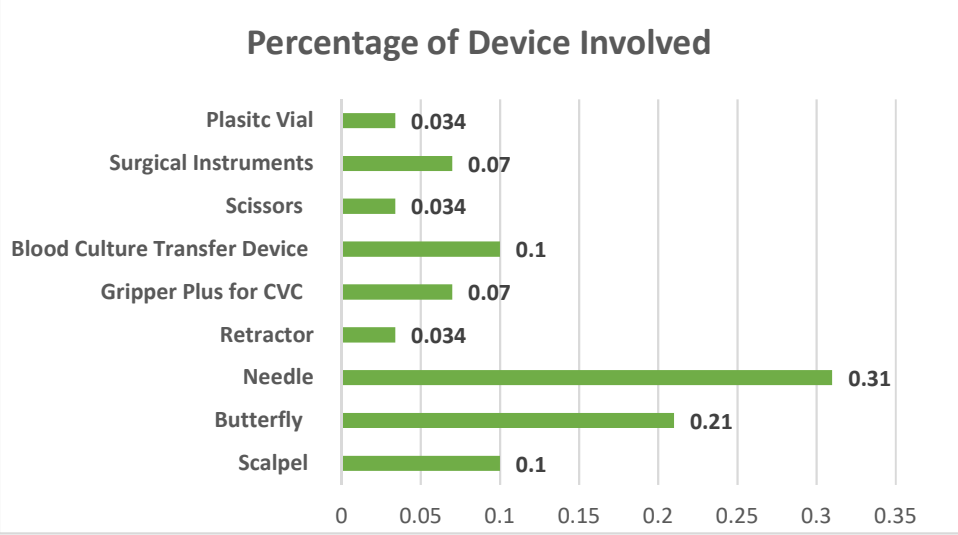
Conclusion:

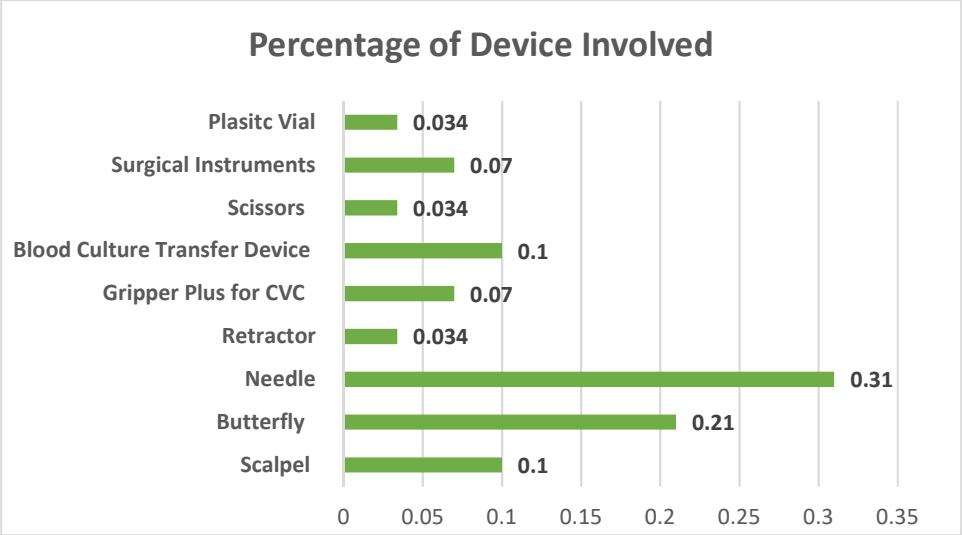
The Infection Prevention and Employee Health teams have made significant strides in maintaining a safe and healthy environment for all staff and patients. The ongoing implementation of evidence-based practices, regular monitoring of infection rates, and continuous education on safety protocols demonstrate our commitment to reducing hospital-acquired infections and enhancing employee well-being. The successful completion of our regulatory reporting, including the CMS/NHSN surveys and compliance with influenza vaccination and sharps injury protocols, underscores our dedication to meeting regulatory requirements and ensuring the highest standards of care.

Looking ahead, the teams will continue to focus on strengthening key initiatives, including infection prevention, antibiotic stewardship, and safe patient handling practices, to further improve patient outcomes and staff safety.


2020-2024 Sharps Injury
12
10
8
6
4
2
0
5
10
4
7
3
# of Injuries
2020
2021
2022
2023
2024


Device Injuries
2022-2024
Device Types
Plasitc Vial
Scissors
Gripper Plus for CVC
Needle
Scalpel
0
2
4
6
8
10
Number of Injuries


Percentage of Device Involved
Plasitc Vial
0.034
Surgical Instruments
0.07
Scissors
0.034
Blood Culture Transfer Device
0.1
Gripper Plus for CVC
0.07
Retractor
0.034
Needle
0.31
Butterfly
0.21
Scalpel
0.1
0
0.05
0.1
0.15
0.2
0.25
0.3
0.35


Percentage of Device Involved
Plasitc Vial
Surgical Instruments
Scissors
Blood Culture Transfer Device
Gripper Plus for CVC
Retractor
Needle
Butterfly
Scalpel
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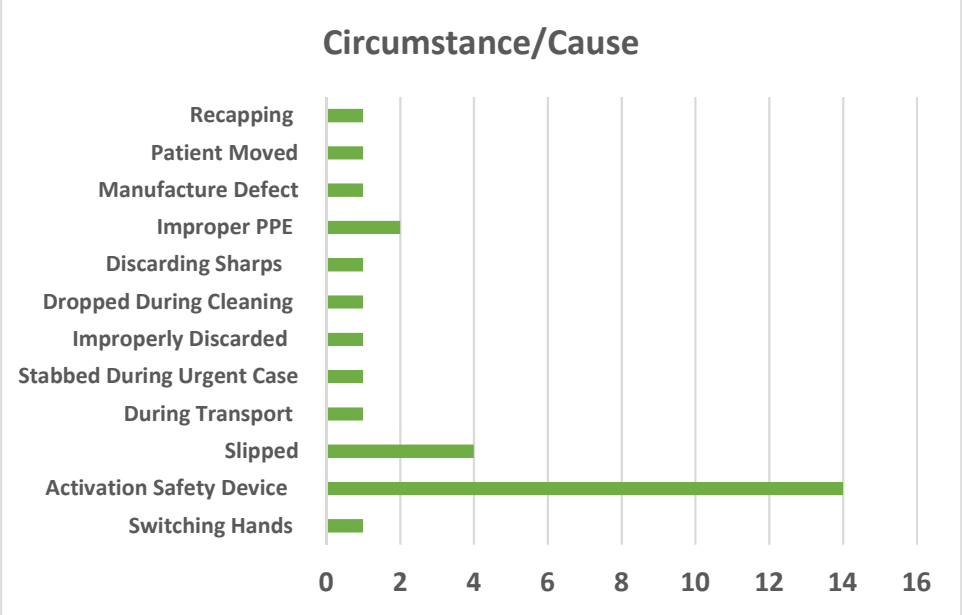
Circumstance/Cause
Recapping
Patient Moved
Manufacture Defect
Improper PPE
Discarding Sharps
Dropped During Cleaning
Improperly Discarded
Stabbed During Urgent Case
During Transport
Slipped
Activation Safety Device
Switching Hands
0
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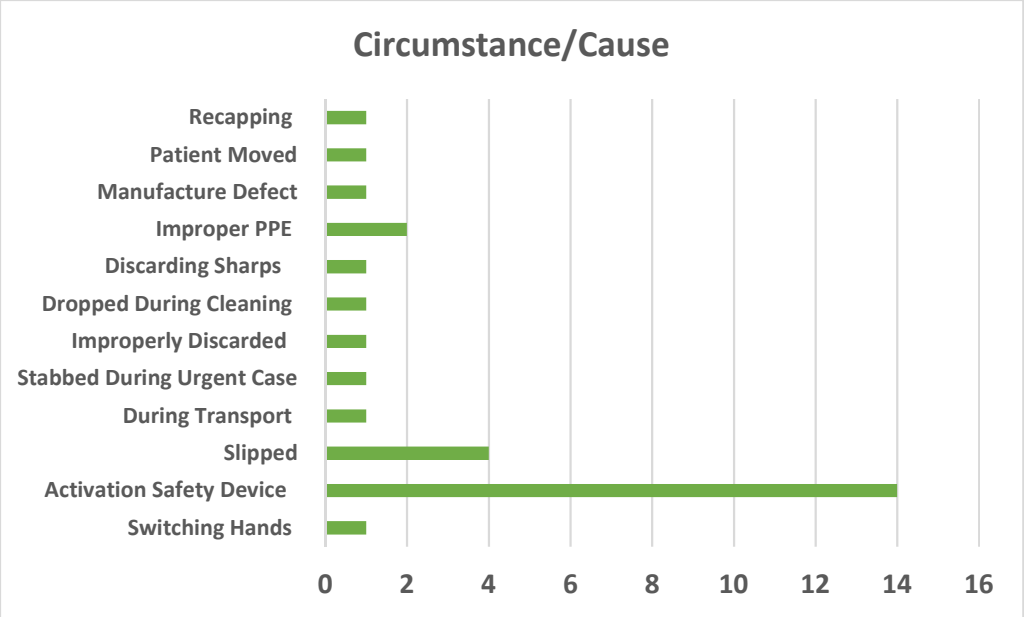
4
6
8
10
12
14
16



2023-2024 Surgical Site Infections

2024

Month Surgery Performed	Month SSI Identified/Reported	Surgery Type	# of Surgeries Performed	PATOS Yes Does not impact SIR Rate	SSI Risk Ranking	Type of Infection	Reported NHSN or Internally
January	January	Colon	2	**YES**	2	Organ Space	NHSN
January	January	Small Bowel	2	NO	4	Organ Space	NHSN
March	March	Amputation	1	**YES**	NA	Organ Space	Internal
April	May	Chole	2	No	17	Deep Incisional	NHSN
July	August	Appy	3	NO	12	Organ Space	NHSN
August	Sept	Ovarian	6	NO	18	Superficial Incisional Primary (SIP)	NHSN
August	Sept	Ovarian	6	NO	18	Superficial Incisional Primary (SIP)	NHSN
September	September	Appy	2	**YES**	12	Organ Space IAB	NHSN

2023

Month Reported	Surgery Type	SSI Rank	Type of Infection	Report Internal/NHSN
January	Hernia	13	Superficial (SIP)	Internal
January	C-section	10	Deep Incisional (DIP)	NHSN
April	Cholecystectomy	17	Organ Space (IAB)	NHSN
April	Tendon Repair	NA	Superficial (SIP)	Internal
August	Colon	2	Organ Space (IAB)	NHSN
August	Colon	2	Deep Incisional (DIP)	NHSN
September	Colon	2	Superficial (SIP)	NHSN
October	Colon	2	Superficial (SIP)	NHSN
October	C-section	10	Organ Space (OREP)	NHSN

NOTE: PATOS =YES Does not impact Standardized Infection Ratio (SIR) but required to report to NHSN for reportable procedures.

The standardized infection ratio (SIR) is a risk-adjusted summary measure that compares the observed number of infections to the predicted number of infections based on NHSN aggregate data. Used to track HAIs over time at a national, state, or facility level.

Acronym	Title	Definition	Reporting Frequency
ABUTI	Asymptomatic Bacteremia Urinary Tract Infection	Can be catheter associated (CAUTI) or non-catheter associated	Monthly- NHSN
AR	Antimicrobial Resistance	Antimicrobial resistance (AR) is when microorganisms, like bacteria, viruses, and fungi, develop the ability to withstand the drugs that treat them	Monthly- NHSN
AU	Antimicrobial Use	Tracks and measures the use of antimicrobials in the hospital	Monthly- NHSN
BBP Exposure	Blood borne pathogen exposure	Contact with blood or potentially infectious body fluids through the eyes, mouth, mucous membranes or broken skin. Blood borne pathogens include Hepatitis B and C virus and HIV	
BSI	Bloodstream Infection	Positive blood culture in a patient with systemic signs of infection.	
CAD	Cumulative attributable difference	Is the number of infections that must be prevented to achieve a HAI reduction goal	Quarterly as needed
CAUTI	Catheter-Associated Urinary Tract Infection	Bacterial infection of the urinary tract that occurs when germs enter through a urinary catheter	Monthly- NHSN
CDI	Clostridium Difficile Infection	A bacterium that can cause inflammation of the colon (colitis). It is a common cause of antibiotic-associated diarrhea (AAD) and can lead to serious complication	Monthly- NHSN
CLABSI	Central Line Associated Blood Stream Infections	It is a type of HAI that occurs when bacteria or other microorganisms enter the bloodstream through a central venous catheter (CVC), which is a tube inserted into a major vein (usually in the chest, neck, or groin).	Monthly- NHSN
CO **C-diff**	Community-Onset	LabID Event meeting one of the following criteria: A) collected in an OP location in which the patient was not previously discharged from an inpatient location within the same facility less than or equal to 28 days prior to current date of specimen	Monthly- NHSN

		collection - B) collected in an inpatient location on Hospital Day (HD) 1 [day of admission], HD 2 or HD 3	
CO-HCFA **C-diff**	Community-Onset Healthcare Facility Associated	Occurs in a patient who was recently discharged (DC) from a healthcare facility. Examples: • Patient was DC from facility within 4 weeks of specimen collection date. • The patient had an overnight stay a at facility within 12 weeks before specimen collection date • Patient symptoms began in the community or within 48 hours of admission.	Monthly- NHSN
DIP-SSI	Deep Incisional Primary Surgical Site Infection	Occurs beneath the incision in at the muscle or fascia or surrounding area	Monthly- NHSN
EBP	Evidenced-Based Practices	A systematic approach to healthcare decision-making that integrates the best practices available research evidence, clinical expertise and patient values.	
HAI	Healthcare-Associated Infection	It's an infection that develop in a patient while they are receiving treatment in a healthcare facility	Monthly- NHSN
HO	Healthcare facility-Onset	Condition or illness began in a hospital rather than the community	Monthly- NHSN
MDRO	Multi-Drug Resistant Organism	LabID Event collected from an inpatient location on or after Hospital Day (HD) 4 where HD 1 is day of admission	Monthly- NHSN
MRSA-Bacteremia	Methicillin Resistant Staph Aureus Blood Stream Infection	A positive results for MRSA from a blood culture monitored in ED and Inpatient areas	Monthly- NHSN
NHSN	National Health & Safety Network	It is a system fir reporting HAIs in the US. The CDC created, and maintains the system. It tracks, collects and analyzes data on HAIs and helps identify and control HAIs	

Organ or Space SSI	Organ or Space Surgical Site Infection	Occurs in an organ or space between organs, rather than in skin, muscle or surrounding tissue.	Monthly- NHSN
PATOS	Infection present at time of surgery	Evidence of infection visualized during the surgical procedure to which the subsequent SSI is attributed. The infection must be documented in the operation note.	Monthly- NHSN
PNEU-HAI	Pneumonia Healthcare-Associated	Is identified by using a combination of imaging, clinical and laboratory criteria	Monthly- NHSN
SIP-SSI	Superficial Incisional Primary Surgical Site Infection	SSI that occurs at the primary incision.	Monthly- NHSN
SIR	Standard-Infection Ratio	A measure used to track HAIs over time. It compares the number of reported HAIs to the number of predicted HAIs, based on NHSN baseline data. The SIR adjusts for several factors that may impact the risk of acquiring an HAI	Quarterly –NHSN
SSI	Surgical Site Infection	An infection that occurs after surgery in the area of body where the surgery occurred	Monthly Reporting Monitor 40-90 days after surgical event
SUR	Standard Utilization Ratio	The primary summary measure used by the National Healthcare Safety Network (NHSN) to compare device utilization at the national, state, or facility level by tracking central line, urinary catheter, and ventilator use. Tracking device use in healthcare settings is essential to measuring exposure for device-associated infections.	Quarterly to Department
SUTI	Symptomatic Urinary Tract Infection	Can be catheter associated (CAUTI) or non-catheter associated	Monthly- NHSN
TAP Report	Targeted Assessment for Prevention Strategy	The TAP strategy allows for the ranking of facilities (or locations) in order to identify and target those areas with the greatest need for improvement.	Quarterly as needed- NHSN
UTI	Urinary tract Infection	Bacterial infection that occurs in the urinary tract	Monthly- NHSN

VAC	Ventilator-Associated Condition	Is a sustained increase in ventilator setting after a period of stability	Monthly- NHSN
VAE	Ventilator-Associated Event	A complication or infection that occurs while a patient is using a mechanical ventilator.	Monthly- NHSN
VAP	Ventilator-Associated Pneumonia	A lung infection that develops in patients who have been on a mechanical ventilator for more than 48 hours.	Monthly- NHSN
VRE	Vancomycin-Resistant Enterococcus Bacteremia	A positive blood culture for vancomycin-resistant enterococcus	Monthly- NHSN

ANTIBIOTIC STEWARDSHIP PLAN (ASP)
ANNUAL GOALS CY 2024

GOAL/AIM	Strategies/ Data Collection	MEASURE OF SUCCESS	YTD OUTCOME EVALUATION	Improvement Activities/Communication
Improve communication and documentation within Electronic Health Record on antibiotic therapy by Pharmacy team with Inpatient Med-Surgical and ICU patients by following the below of optimal antimicrobial therapy: ○ Right Drug ○ Right Dose ○ De-escalation to pathogen directed therapy ○ Right Duration of therapy ○ Allergies *Exclusion Criteria:* • *Order for discharge placed prior to IDT*	**Providers, Pharmacists, Nursing, Infection Prevention** • Review antibiotic therapy at daily interdisciplinary meeting • Review Culture Results **Pharmacists** • Documentation of antibiotic discussion within patient electronic record **Infection Prevention** • Chart Review for all patients in house every Thursday who are on antibiotics. • Report at least annually to P&T/ Quality Council, ATB	**Quarter 1: NA** Started planning goals. Text Macro created by Adam Jesionek. Need to share with Pharmacy staff. **Quarter 2: 71%** **Quarter 3:** **Quarter 4** **Year to Date:**	**Quarter 1 Met** **Jan-March** **Quarter 2** NOT MET 78 % **April-June** **Quarter 3 72 %** **July-September** **Quarter 4** **Oct-Dec 96%** **YTD 82% MET** **AIM:** Improve communication and documentation within Electronic Health Record on antibiotic therapy by Pharmacy team with Inpatient Med-Surgical and ICU patients. | **Goal 80%** | **YTD Evaluation 82% Goal Met**	• Pharmacists educated on text macro and documentation. ○ Jenny Nguyen 4/5/24 ○ Han (Eddie) Kwon 4/11/2024 ○ Jeff Kneip 5/31/2024 ○ Jillene Freis 4/28/2024 • 5/23/24 0% Pharmacy Documentation. Pharmacist covering was not trained. Training completed 5/31/2024

Created 1/24 ASP team

ANTIBIOTIC STEWARDSHIP PLAN (ASP)
ANNUAL GOALS CY 2024

• *Patients admitted following IDT* • *Total Joints* • *Pediatric Patients* • *Patients not on ATB* **Goal: 80%**	Stewardship, Infection Prevention			
Decrease mixed flora urine cultures throughout the organization. 2024 **Goal**: Implementation and baseline tracking. Baseline data: 9/23 34/200 = 17 % Key Stakeholders implementing: Hannah, Jen Joos and Dr. Hawkins:	• Cascade build (proposed) Urine dipstick analysis w/ microscopic analysis if indicated w/ culture if indicated.(Hannah and Dr. Hawkins) • Order-set update (Clinical Informatics and Lab) • Nursing & patient education UA collection	**Quarter 1:** Metric goal/aim determined **Quarter 2:** See improvement activities /communication **Quarter 3:** **Quarter 4** **Year to Date:**	**Quarter 1 Met** **Quarter 2** Partially met **Quarter 3 Continue to monitor Have information 1 month post cascade information** **Quarter 4 MET Project Implemented See below Collection data Pre and Post Implementation** **Action Plan: Will continue to monitor 2025**	• **Cerner Reports:** 5/18/2024 Received email from Sandra Sommer stating Cerner Urine Cultures Report Completed • **Urine Cascade:** 7/16/24 Received email from Hannah indicating that all providers have been notified about new UA cascade. Information included: ○ Cascade Build 6/13/2024 ○ Letter to provide UA Cascade dated6-13-24includes workflow and order codes. ○ Urinalysis Cascade Decision Tree Dated May 2024 ○ Email sent to providers dated 6/17/2024 • **Cerner Order Set:** Pending Cerner

ANTIBIOTIC STEWARDSHIP PLAN (ASP)
ANNUAL GOALS CY 2024

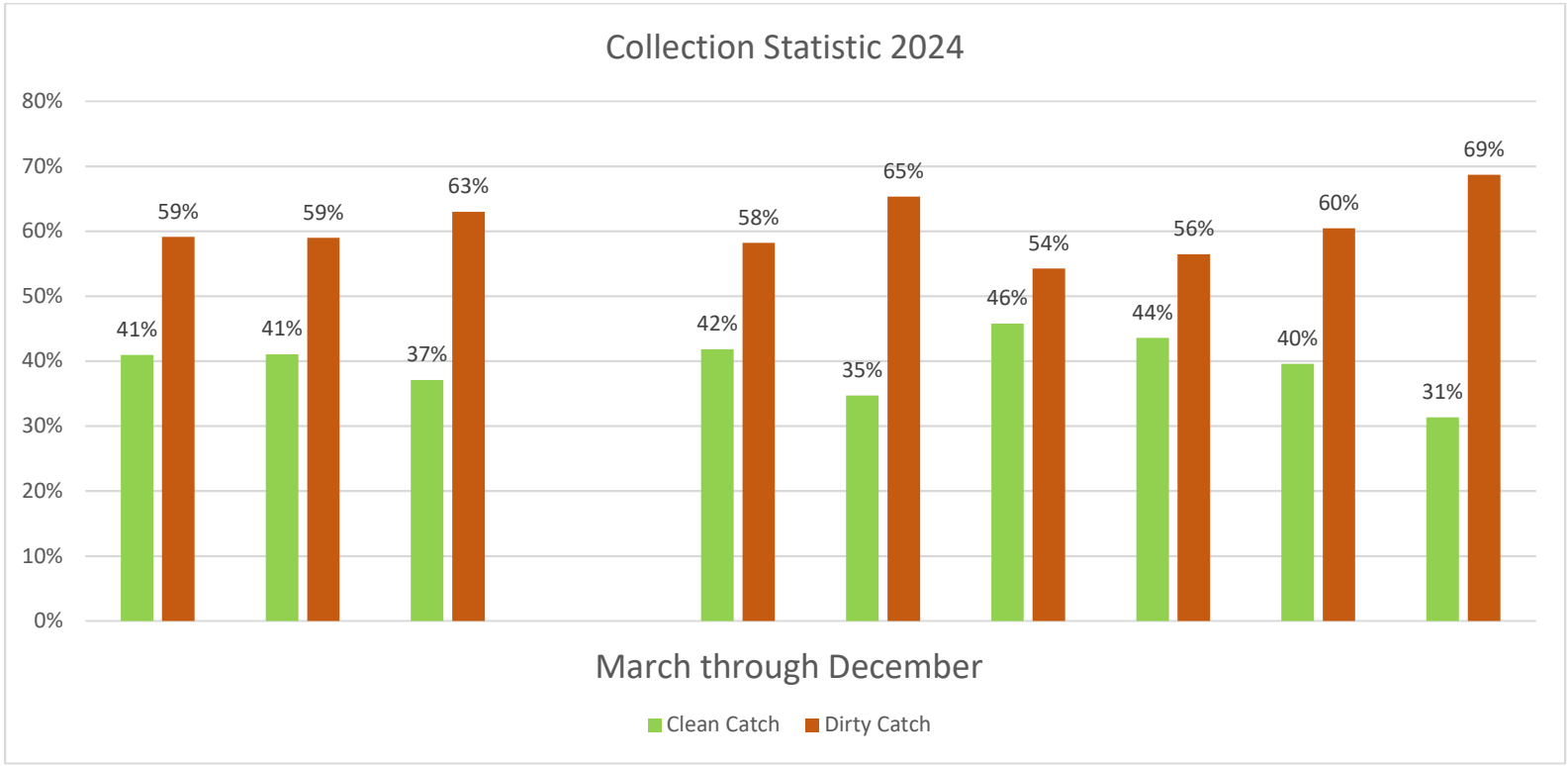
	• Implementation preservative tubes
	
	Sandra & Cerner
	
	• Report for data collection include the below elements
	  ○ Mixed flora
	  ○ Hold
	  ○ Normal Flora
	  ○ No Growth
				• **Implementation Preservative Tubes:** Pending
				• **Staff and Patient Education:** Pending need to determine how education will be implemented

UC Results Tracker Monthly:

Created 1/24 ASP team

ANTIBIOTIC STEWARDSHIP PLAN (ASP)
ANNUAL GOALS CY 2024

Total Urine cultures	Month	Work-up	No growth	Normal flora	Contamination	HOLD	Amend	Clean Catch	Dirty Catch	Month	
176	March	63	9	66	34	4	0	41%	59%	March	
173	April	47	24	67	24	11	3	41%	59%	April	
197	May	57	16	86	18	20	6	37%	63%	May	
182	June	Implementation Urine Cascade 6/13/2024								June	
177	July	58	16	59	27	17	2	42%	58%	July	
170	August	45	14	74	21	16	4	35%	65%	August	Posters/Education 8/27/2024
201	September	69	23	68	28	13	6	46%	54%	September	
202	October	61	27	75	26	13	1	44%	56%	October	
139	November	40	15	43	25	16	2	40%	60%	November	
201	December	41	22	75	44	19	3	31%	69%	December	



Created 1/24 ASP team

NORTHERN INYO HOSPITAL

CQSR

Infection Prevention/Employee Health

Pillars of Excellence: FY 2025

July 1, 2024-June 30, 2025

Indicator	Baseline	Goal	Q1 July-Sept	Q2 Oct-Dec	Q3 Jan-March	Q4 April-June	YTD
Service	**Data FY 2024**						
1. Monthly NIHD Blood Culture Contamination Rates *Note: See Monthly/CY Below Screen shots*	FY 2024 1.7%	<= 3%	July 3.9 Aug 3.6 Sept 1.4 8.9/3 3%	Oct 2.7 % Nov 1.1% Dec 3.1% 6.9/3 2.3%			**15.8** **2.63%**
2. C-Diff Standard Infection Ratio (SIR) SIR=: # of Hospital Onset Infections / Predicted # if Infection *Note: See SIR definition below*	0.715	<=1	0 # predicted 0.189 0	1 0.166 6.02			1 0.355 SIR 2.82
Quality							
1. Hand Hygiene compliance per W.H.O guidelines a. N= Compliant D =Observed	95 % N= 1542 D= 1616	96%	98 % N = 470 D = 477	97.5 % N= 320 D= 328			98 % N = 790 D = 805
2. Percentage of HCW Influenza vaccinated	434/632 69%	> 72%	358/582 62%	466/594 78%			466/594 78%
3. Percentage of HCW with Documented declination	153/632 24%	<21%	26/582 4%	60/594 78%			60/594 78%
4. Percentage of HCW with Medical Contraindications.	NA	NA	3/582 0.5%	3/594 0.5%			3/594 0.5%
5. Number of HCW with Unknown Status **Note: Per CMS/CDC guidelines this will be counted as declination*	43/632 7%	< 7%	195 /582 33.5%	65/594 11%			73/594 11%
People							
1. Total Healthcare Workers exposure to Blood borne Pathogens							

a Blood via percutaneous sharps injury	9	7	p1	0			1
b Blood splash or spray to mucous membranes.	0	2	1	0			1
2. Total Number of Employees Injured due to unsafe Safe Patient Handling	1	0	0	0			0
Finance							
1. The number of CLABSI Reported to NHSN (Patient Days)	0 99	0	0 34	0 25			0 59
2. The Number of : a. Catheter Associated UTI's (CAUT's) b. Non-Catheter reported to NHSN	a. 0 b. 1	a. 0 b. 0	a. 0 b. 0 75	a. 0 b. 0 118			a. 0 b. 0 193
3. Number of Hospital Onset C-diff *PD = # Total InPt days **w/out** baby, Incl. OBS & Swing*	0 PD 3235	0	0 856	1 751			1 1607
4. The number Surgical Site Infections (SSI) Reported to **NHSN** a. Superficial Incisional (SIP) b. Deep Incisional Primary (DIP) **c.** Organ Space	6 a. 1 b. 2 c. 3	0	3 a. 2 b. 0 c. 1	0 a. 0 b. 0 c. 0			3 a. 2 b. 0 c. 1
5. Number of NHSN Reportable Surgeries with **PATOS** when SSI identified a. Superficial Incisional (SIP) b. Deep Incisional Primary (DIP) **c.** Organ Space	NEW a. 0 b. 1 c. 1		a. 0 b. 0 c. 1	a. 0 b. 0 c. 0			a. 0 b. 0 c. 1
6. The number Surgical Site Infections (SSI) Reported **Internally** a. Superficial Incisional (SIP) b. Deep Incisional Primary (DIP) c. Organ Space	a. b. c. 1	0	a. 0 b. 0 c. 0	a. 0 b. 0 c. 0			a. 0 b. 0 c. 0
7. Number of NHSN **non**-reported surgeries with PATOS when SSI identified. This include reportable Outpatient surgeries and internal reporting	a. 0 b. 0 c. 1		a. 0 b. 0 c. 0	a. 0 b. 0 c. 0			a. 0 b. 0 c. 0

Pillars of Excellence: Color Legend

LEGEND	
	Best-in-Class Performance, Exceeds Goal
	Above Average, Meets Goal
	About Average, Does Not Meet Goal
	Below Average, Does Not Meet Goal

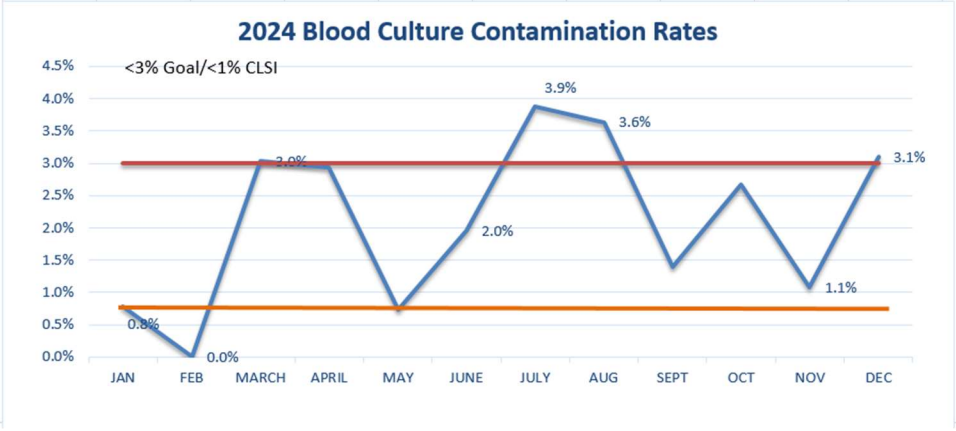
Important Notes:

1. Goals in Blue are stretch goals and may follow a 'zero defects' approach outlined in the Hospital-Wide Quality Assurance and Performance Improvement (QAPI) plan. On some metrics, we have set the bold goal of zero defects (best-in-class). For the metrics with a goal of zero, either we are best-in-class and get a blue color code or not best-in-class and get a red code. It is important to note that a code of red in the 'Quality' category of indicators for metrics with goals of zero does not necessarily indicate poor performance, just that we have not met our goal of zero. For example, on Surgical Site Infections for Quarter 1, FY 15-16, we did not meet our goal of zero defects, but are still outperforming most of the country with an infection rate of 4 times LOWER than the national average of 2.0%.
2. Patient Satisfaction/Patient Experience-For each department the highest number of frequencies determines the overall assignment of Red (Below Average), Yellow (About Average), Green (Above Average), or Blue (Best in Class). It is recommended that specific performance categories be assessed by area leadership to identify opportunities for improvement.
3. Benchmark data for these metrics only available per annum and since the number of incidents accumulates, but number of employees is relatively constant, it is most appropriate to compare only per annum data to the goal.

2024 Contaminated Blood Cultures

Northern Inyo Hospital Collections

	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	2024
% Contaminated	0.8%	0.0%	3.0%	2.9%	0.7%	2.0%	3.9%	3.6%	1.4%	2.7%	1.1%	3.1%	2.1%
Benchmark (NIHD)	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%
2022 Benchmark (CLSI)	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%
Total # Blood Culture	128	89	99	102	136	102	103	110	143	112	93	98	1315
# Contaminated (A#)	1	0	3	3	1	2	4	4	2	3	1	3	27



NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.

DATE: March 19, 2025

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Dianne Picken, Medical Staff Director

RE: Medical Staff Report: CQSRC

RECAP OF LAST REPORT:

Last quarter, we learned the definitions of credentialing and privileging, as well as who needs to be credentialed and privileged and why. Lastly, we learned that the Medical Staff is responsible to the Board of Directors for maintaining a credentials program. Let's take a deeper dive into this program.

WHAT DOES CREDENTIALING AND PRIVILEGING LOOK LIKE AT NIHD?

Prior to a new Medical Staff member providing any services to our patients, he or she must be credentialed and privileged to perform these services. Think patient safety. Below are the basic steps:

1. An applicant submits an application to the Medical Staff Office.
2. The Medical Staff Office conducts verifications of the information provided.
3. The organized Medical Staff reviews all information and decides to recommend or not recommend the applicant for approval.
4. The Board of Directors receives the recommendation of the Medical Staff and takes final action.

Let's expand on the above 4 steps further:

1. *An applicant submits an application to the Medical Staff Office.*
   - ➔ We use an online application where a practitioner provides their licensure information, work history, peer references, education/training information, and other qualifications. Applicants also attest to any previous malpractice claims, disciplinary actions, and to their health status. They are also required to undergo a criminal background check.

2. *The Medical Staff Office conducts verifications of the information provided.*
   - ➔ The Medical Staff Office conducts "primary source verification," which means we go directly to the original source to obtain a verification (for example, primary source verification of training means we contact the school or agency to verify training was completed satisfactorily; we would never accept a photocopy of a diploma from the applicant as sufficient evidence that a residency program was completed).
   - ➔ The Medical Staff Office also queries the National Practitioner Data Bank, as required by law, to assess whether the practitioner has any disciplinary actions by other hospitals or state agencies, or any malpractice settlements.

3. *The organized Medical Staff reviews all information and decides to recommend or not recommend the applicant for approval.*
   ➔ After the credentialing process is completed in Step 2, the Medical Staff reviews the information and makes an assessment of the privileges that an applicant is qualified to perform. The persons involved in this process are: the relevant Department Chief (ex: Chief of Anesthesia), the Credentials Committee (comprised of 5 physician's from various specialties), and the Medical Executive Committee (the elected Medical Staff leaders).

4. *The Board of Directors receives the recommendation of the Medical Staff and takes final action.*
   ➔ The Board of Directors receives a monthly Chief of Staff report where the Medical Staff's recommendations for appointment or reappointment are listed. The Board of Directors may adopt, modify, or reject the recommendation of the Medical Executive Committee (note: rejection would trigger procedural rights for the applicant, a topic for another time).

CONCLUSION:

The Medical Staff Bylaws list the qualifications and requirements of all practitioners that seek privileges at Northern Inyo Healthcare District. A robust credentials program upholds the Bylaws and not only ensures all applicants are evaluated fairly and thoroughly, it is also important for patient safety.

FUN FACTS:

- The NIHD Medical Staff Office completes the credentialing process, on average, in **20 days**. California's "gold standard" is 21 days and users of our software nationwide average 28 days.
- Privileging involves committee approvals, which can take an additional **30-60 days**.
- Privileges are granted for a maximum of 24 months as per California law. A member of the Medical Staff must undergo re-credentialing every two years.
- The re-credentialing process is much like the initial credentialing process, with the exception that static information does not need to be re-verified (like the completion of a medical degree (M.D.), which does not change after it has been verified initially).
- If an applicant wishes to request additional privileges at any time during their appointment, re-credentialing is performed.

DEFINITIONS:

- **Appointment** - the act of approving a practitioner to become a member of the Medical Staff, which includes a specified duration of time for the approval (maximum of two years).
- **Credentialing** - the process of obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization.
- **National Practitioner Data Bank (NPDB) -** a clearinghouse of confidential information that must be queried (searched) by a hospital any time a practitioner has applied for privileges. Entities like hospitals and malpractice carriers must report certain actions to the NPDB.
- **Primary Source Verification (PSV)** - the process of confirming a person's qualifications and credentials through the original source of the information.
- **Privileging** - the process of evaluating all the elements obtained through the credentialing process to determine what patient care services a practitioner is permitted to perform.
- **Reappointment** - the renewal of an initial appointment; performed every two years.